Drug policy changes slated for spring?

By Jeff Carruthers

OTTAWA — Federal Health Minister Monique Begin and Justice Minister Marc Lalonde (former health minister) are working up a package of major drug policy changes that will likely be announced early in 1979, just before the spring federal election.

Under consideration is the long-awaited relaxation of penalties for cannabis possession crimes, as well as an unexpected proposal to transfer away from the health department certain administrative powers associated with drug crimes.

Ms Begin told **The Journal** that "certain police powers" do not properly belong within the health department and should be transferred to a more appropriate agency.

Reference was made to the powers given the health minister relating to the seizure and disposition of automobiles, boats, and aircraft believed to have been used for drug crimes.

Under certain instances, the Narcotic Control Act makes the health minister responsible for deciding, for example, whether seized vehicles, money, and other items connected with drug crimes, should be kept by the government or returned to their rightful owners.

Often, it is unclear whether the property was, in fact, used in connection with a crime and who owns it.

It has been recognized for a long time within the department that, in many instances, neither the health minister nor the health department bureaucrats are in the best position to decide. Most often it is the court that heard the evidence leading up to a conviction, that is best able to determine, for example, whether an aircraft used in a crime really belongs to someone who was unconnected with the crime but unwittingly lent or rented the vehicle for use in a crime.

With this in mind, legislative changes could either transfer the responsibility to the justice department or the judiciary.

Curiously enough, the requirement to gather information for deciding disposition of seized goods was a key rationale offered by the health department for the keeping of detailed personal files on known and suspected drug users in Canada — files that until recently had been kept secret (**The Journal**, Dec 1978.)

Other changes under consideration include modifying the powers of search and seizure now given drug squad members and customs officers involved in drug investigations, especially those relating to search of private property without a court issued warrant.

At present, designated members of the RCMP may use blanket warrants called "writs of assistance" to enter any house in search of narcotics, and judges may issue search warrants based solely on evidence from a police officer that he or she believes narcotics might be present in a particular location.

While the power to issue writs of assistance has already been transferred from the health minister to the justice minister in drug cases, further changes are being contemplated to limit both the number and duration of those issued, and perhaps even limit their scope.

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It's the Year of the Child . . . *. . . and around the world United Nations' member countries are urging people to "Renew their concern for children — our world's most precious resource." See centrespread and coming issues.*

Begin blasts BC plan

VANCOUVER — Federal health minister Monique Begin tangled with the British Columbia compulsory heroin plan on a radio talk show here, emerging bloodied but unshaken in her opposition.

"It will be like prison; it will be custodial more than anything else," she said of the plan, which was set to come into effect Jan 1.

"Compulsion has never worked in the treatment of addiction. It is my viewpoint as minister of health, if people aren't motivated it won't work."

But when Ms Begin rang off, two top figures in the BC plan lit into her in response.

Bert Hoskin, chairman of the BC Alcohol and Drug Commission, called her "one of the most ill-advised, ill-informed ministers in the history of drug dependency.

"As long as the problem is this side of the Rockies, they couldn't give a damn."

Contradicting statements by Ms Begin, he said compulsory treatment has worked, the province is providing other facilities than the 150-bed detention unit, and medical treatment staff have been hired.

He also quarreled over figures. The province has asked federal government for $3.4 million in startup costs and $9.4 million a year, not $16 million, he said.

(The federal government has said it will give the program nothing at all. Provincial health minister Bob McClelland failed again to get any support when he attempted to see the federal minister in Ottawa shortly after the radio program.)

Provincial judge Les Bewley, on leave to serve as legal counsel for the heroin program, joined Mr Hoskin in condemning Ms Begin.

"Frankly, I'm stunned . . . I reckon the best anybody can do is use prayer."

Puzzle of paraquat: 'Nobody knows'

WASHINGTON — Many who feared that paraquat-contaminated marijuana would cause lung damage have now swung to the belief that the herbicide is destroyed during smoking. Problem is — nobody knows who's right.

This is the experience of David Smith, medical director of the Haight-Ashbury Free Medical Clinic, following the panic when it was reported marijuana contaminated with the herbicide was reaching the United States from Mexico.

Dr Smith said his clinic was inundated with callers after the story appeared and "there was a severe psychological panic with agitation and depression and the feeling by a lot of people that they were being poisoned."

He and his colleagues hypothesized "that paraquat is destroyed during smoking."

Dr Smith said that during the height of the scare, "we saw approximately 50 individuals who came in with respiratory distress. Some were coughing up blood, and some reported a burning in the back of the throat.

"We found that none of the patients had pulmonary lung deficiency."

Dr Smith, in a report to the annual meeting of the National Organization for the Reform of Marijuana Laws (NORML), said an extensive study was made of a 17-year-old male who had a classic clinical picture for paraquat inhalation: respiratory distress, two episodes of coughing up blood, and burning at the back of the throat. He smoked an average of two marijuana cigarettes a day.

"However, his pulmonary function was found to be completely normal," he added.

Dr Smith said he felt the irritation was caused by heavy marijuana use and his condition was exaggerated by the paraquat panic.

"We could have said that definitively if we had known for sure there was paraquat on his marijuana, but we didn't."

Dr Smith is worried that those who first feared lung damage from paraquat, now believe there is nothing to worry about because smoking destroys it.

"We just don't know."

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Heroin in the US: Raising need for maintenance trials

SAN FRANCISCO — Heroin use appears to have become an endemic problem in the United States and it is now time to consider controlled trials of heroin maintenance, believes David Smith, medical director of the Haight-Ashbury Free Medical Clinic here.

Dr Smith says an apparent rise in heroin use in the San Francisco area, following a two year drop, indicates "it is an endemic problem which will continue to go up and down and up and down.

"For this reason I am moving more to the position that we should have controlled trials of heroin maintenance. I think the idea that we will ever get rid of heroin is a totally false one."

Pilot programs could be carried out along lines which the British have used for years. "You would need to work out the logistical details and see how it works," he told **The Journal**.

Methadone maintenance can help many addicts "but a lot can't be helped either. Along with this we have the crime problems associated with heroin addicts, and the health consequences for them which depend on the quality of heroin they obtain."

Dr Smith's clinic runs a detoxification service for addicts but it does not have a methadone maintenance service "as we are oriented to a drug free philosophy. However, we support the city health department which supplies methadone for those in need."

Meanwhile, the present economic climate in California, following adoption of proposition 13 which lowers property taxes, is producing cuts in social and welfare programs. Dr Smith adds: "We must now deal realistically with these problems."

Dr Smith is dealing with his own problems resulting from proposition 13. "Starting in June, our medical section will be devastated because we have been told we will lose $100,000 which has been allocated from the city budget."

All of the doctors, including Dr Smith, are volunteers but the paid staff in the medical service department will have to leave. The clinic's specialty services, such as the detoxification clinic, counselling services, and women's needs groups, will continue.

Dr Smith said since the clinic was founded in 1966 "the only policy I have had is never to become dependent on one source of funding, and I have always advised others of this.

"We have been through crises before and pulled out. There are going to be huge cutbacks in other services in San Francisco so one can't conjure up a paranoia that you are being picked out: you must look at the broader picture."

Addicts leaving BC voluntary clinics

By Tim Padmore

VANCOUVER — As the shadow of British Columbia's compulsory heroin treatment plan loomed, addicts were dropping out of pre-existing voluntary programs.

There were 97 fewer addicts in treatment at the start of December than six months earlier, a drop of nearly a quarter.

Bert Hoskin, chairman of the Alcohol and Drug Commission acknowledged the drop after an enquiry by **The Journal**, but had no explanation except to say the figures are "up and down".

Jim Dybikowski, president of the BC Civil Liberties Association, said the most likely explanation is addicts can no longer trust the commission, which runs both the old and new programs.

Addicts in the voluntary programs had been told that as of Jan 1 they would go into the compulsory program. Also, records of voluntary treatment were to be turned over to the administrators of the compulsory plan.

The drop is discouraging to the commission, which looked to the volunteer programs to provide the bulk of its customers in the first months.

That's because police referrals have been postponed and court referrals limited to a trickle because of legal problems.

The commission had hoped to encourage addicts to stay, by promising those on methadone maintenance before last June (1978) that they would be able to continue under the compulsory plan, even though methadone is to be used sparingly in the new regime.

The drop reverses a normal seasonal trend. It is apparently not due to addicts fleeing the province. Police spokesmen in Seattle and Calgary said there were no significant numbers of Vancouver addicts coming to their cities, despite a shortage of heroin in Vancouver and the threat of the compulsory program.

Mr Dybikowski said two other factors might have contributed to the attrition in the volunteer programs — loss of the long term methadone option; and a real decrease in the number of heroin addicts.

He recalled the report of a joint provincial-federal task force which found that most indicators showed the heroin problem in BC declining from a peak around 1972.

NORML's call: Legal pot sale/use

WASHINGTON — Legal sale and use of marijuana is now the official policy of the National Organization for the Reform of Marijuana Laws (NORML).

The 135-member national policy committee decided on the policy change at the organization's annual meeting here. For the past nine years, NORML has campaigned to reduce the criminal penalties for personal use of the drug.

Opposite views on the move have been taken by two leading medical supporters of NORML, David Smith and Thomas Ungerleider.

Dr Smith, director of the Haight-Ashbury Free Medical Clinic, San Francisco, told **The Journal**: "I think the time has come to deal realistically with legalization. Its use as a social and recreational drug is now an established part of the social and cultural fabric of the US.

"If marijuana is legalized, I would like to see funds from its sale earmarked for service programs that would, for example, help reduce drug abuse."

Dr Ungerleider, neuropsychiatric institute, University of California, Los Angeles, said: "I disagree strongly" with the NORML shift.

"One reason I think it is a mistake is the current terrible situation we have with alcohol and advertising. If you are a football fanatic, as I am, you know that almost every commercial on television during football games is a beer commercial.

"I fear also that American business will take over. No matter what research may ever show (about marijuana), in the way the tobacco industry can find doctors to say the evidence about smoking and cancer is not conclusive, the same thing would happen.

"There are some people who can get dependent on any drug, including marijuana, and I just can't be comfortable with that."

Marijuana no narcotic judge finds

OSHAWA — In a 15-page written decision, a provincial court judge has found that marijuana is not a narcotic, basing his finding on expert evidence given during a lengthy trail here.

But Judge Donald B. Dodds found Michael Roscoe Taylor, 32, of Toronto, guilty of possession, saying marijuana was legally included in the schedules of the Narcotic Control Act (NCA) by parliament, and courts could not interfere.

He said "... undesirable laws passed by parliament must rest in the right of free citizens to vote for a change in government ..."

Judge Dodds based his ruling on testimony of both Crown and defence witnesses, who said that scientifically, pharmacologically, and medically, marijuana is not a narcotic. "I am prepared to conclude on the basis of these opinions that cannabis is indeed not a narcotic," Judge Dodds said.

Mr Taylor's Toronto lawyer, Edmond Brown, argued that since it is not, it was included arbitrarily in the NCA and thus is a violation of rights under the Canadian Bill of Rights.

Mr Taylor was given a conditional discharge and a year's probation. It was felt the court battle was a test case and Mr Brown said he will appeal the finding of guilt.

Heroin: 'A subculture rite'

VANCOUVER — Ninety-nine per cent of the heroin users admitted to Oakalla prison in British Columbia are only minimally dependent on heroin, according to a study by a prison medical officer.

Dr R. G. Shulze reports in the *British Columbia Medical Journal* that of 411 randomly chosen inmates who had been labelled "users," 406 showed "nil or negligible" signs of opiate addiction. Only one had "marked" signs of dependence.

Dr Shulze, a sessional medical officer at Oakalla, says he examined all cases within 24 hours of the last "fix" and used standard textbook criteria for evaluating dependency.

He suggests most of the inmates "had used heroin purely as a rite in their subculture." Street heroin available today is very dilute, he says, making it prohibitively expensive to obtain "pharmacologically effective" dosages.

Xanthoids and Mexoids are just...too far out

By Wayne Howell

From: Galacto Media Press
Los Angeles, California

Dear Ms Pennyfeather

Thank you for submitting your manuscript to GalactoMedia. We are always searching for new Sci-Fi talent. Unfortunately, the reaction of our editorial board to *Curse of the Xanthoids* was mixed.

In the first place, we had a great deal of difficulty accepting the basic premise upon which the plot hinges. Why would the Xanthoids, whom you describe as creatures possessing 'incredible cranial capacity' act as they do? First we are told that a chemical called Xiphol, that is known to rot the cognitive centres of indulgent Xanthoids, is freely available in the Xanthoid galaxy. And then we are asked to believe that this chemical of known toxicity is allowed to exist at the same time as the Xanthoids are financing a crop-zapping operation in the neighboring Mexoid galaxy. To destroy what? Not the bulbous cacti-like growths that produce Mexoid Xiphol — but the bush-like growths that produce the chemical THX, the toxicity of which the Xanthoidians have been unable to establish! This just does not make sense Ms Pennyfeather, as long as you insist that the Xanthoids possess 'formidable cognitive skills.'

We can only suggest that you rewrite the entire chapter, either making the basic premise more credible or making the Xanthoids more believable; this is just a suggestion, but have you considered making the Xanthoids more like the miniscule-cortexed, pea-brained Dumitoids — then their behavior would appear more in character.

The whole sub-plot about the Killer Poppies suffers from the same problem: a big credibility gap. I mean look Ms Pennyfeather, if these Xanthoid creatures were just one-half as intelligent as you made them out to be then surely they would have seen that the solution to their unique killer poppy problem would be to restructure or re-jig Xanthoid society so that Xanthoidians wouldn't feel the need for killer poppies, rather than leaping into their huge space ships and hysterically tearing around, coaxing, bribing, and bullying little killer-poppy-producing galaxies to cease production! I just don't think your average science fiction addict would be willing to accept this Ms Pennyfeather. He's used to intelligent creatures from outer space. These Xanthoids are just ..... too far out!

Now, getting back to the main story: the chapter on what happens in the Xanthoid capital when it is discovered incompletely-zapped THX is showing up in the galaxy and rotting the respiratory apparati of THX-using Xanthoids is promising to start with, but then it just falls apart; everything becomes murky and frankly, Ms Pennyfeather, it begins to read like cheap political melodrama. The reader is left with more questions than answers!

For instance, what actually went on at the party where the high-ranking Xanthoid official allegedly compromised himself by assimilating prohibited chemicals into his Xanthoplasm? Did the leader of the THXers see something and did he really threaten to Tell All if the high ranking official did not denounce the THX zap program? Why did both these protagonists end up being banished to the planet Limbo? The whole thing just does not hang together Ms Pennyfeather!

I am sorry I have had to be so negative Ms Pennyfeather. Actually, we did like the denouement very much: when the little Mexoids rose up, took over the THX zapping program, refused to stop it, and threatened that if the all-powerful Xanthoids tried to interfere they would flood the galaxy with Killer Poppies, then we realized what the 'curse' of the Xanthoids was to be : forever after they would have to live with the fact that they had made THX as lethal as xiphol! A neat twist, Ms Pennyfeather. We found it a little far out, but I'm sure even Isaac Asimov got rejection slips when he started out. Do try again.

Yours truly,
The Editor
Galacto Media Press

(Wayne Howell is an Ottawa physician and freelance writer.)

Warning on liquor bottles?

By John Shaughnessy

TORONTO — The North American liquor industry is being pressured to include health warnings with all its products and advertising.

In the United States, Ed Campbell, a Seattle lawyer and recovering alcoholic, has launched a class action suit against the alcoholic beverage industry for more than $500 million dollars and asked for permanent restraint of sale of all liquor without adequate and fair warning given to the consumer on all labels and advertising.

In Canada, federal member of Parliament, James McGrath, has introduced a bill requiring that every television commercial for beer or ale show, within the last five seconds, the warning "Excessive use may lead to addiction or degenerative disease."

Earlier, in Ontario, the Addiction Research Foundation, as part of its Strategy for the Prevention of Alcohol Problems, recommended to the provincial government that a message indicating the principal long term health hazards of alcohol use be distributed through the retail outlets of the Liquor Control Board of Ontario. **(The Journal,** June 1978.)

In an interview with **The Journal,** Mr Campbell said his class action seeks to place primary financial responsibility for the damage from human consumption of alcohol on the alcoholic beverage industry. "Those responsibilities include the duty to warn," he said. "We believe the alcoholic beverage industry has the first responsibility to provide the public with the facts about the true, scientific consequences of drinking alcoholic beverage. We believe that where the consumer is not properly informed he has been denied his right to know. We believe that any member of our American society hurt by alcohol consumption has a right to be paid for his or her damages. We believe the alcoholic beverage industry must pay those damages if it fails to inform."

Mr Campbell noted this type of suit is not new — in fact the food and drug laws and the laws of strict products liability have applied to other foods and beverages for at least the last 35, perhaps 70 years.

"These laws require that the manufacturers and sellers of food and beverages for human consumption warrant that their products are sound, wholesome, and fit to be consumed. If the customer is made sick by the normal use of the product, then he or she has a right to ask the producer or seller for damages caused if that consumer has not been fairly and adequately warned by the profiteer. This is designated as the area of product liability and we are seeking to enforce strict liability on the distillers, brewers, and vinters of alcoholic beverages and their wholesale and retail representatives."

Mr Campbell said he will also be using the Uniform Washington State Food, Drug and Cosmetic Act which prohibits false labelling and advertising.

Alcohol abuse on increase in Canada

By Manfred Jager

WINNIPEG — Alcohol abuse in Canada is on the increase and will continue so at least for another decade, the new president of the Canadian Addictions Foundation has warned.

Lorne Phillips, director of provincial programs for the Alcoholism Foundation of Manitoba, said in an interview it will take the next 10 years to continue with the development of more and better prevention and education programs before the point is reached at which especially young people fully realize that too much liquor reduces the quality of their lives and hurts their future health.

"For the time being, we're still going to be picking up the pieces after the fact, with an emphasis on treatment programs for people who have become alcoholics or have suffered health damage through alcohol abuse," Dr Phillips said.

Five studies in high schools across Manitoba, for example, recently revealed alcohol use to be so widespread among students that so-called social drinker, alcohol abuser, and alcoholic ratios are the same in the school population as they are among adults.

Part of the reason for this, according to Dr Phillips, is liquor is cheap and easy to obtain, even for people too young to purchase it legally themselves.

"Buying booze just is not that much of a problem, let's face it. We are an affluent society and booze is cheap. Our living standard still is sufficiently high to make it possible with no trouble at all for those who want to have the stuff around the house," he said.

Lorne Phillips: 'Canada is progressive in approach to alcoholism.'

The Canadian experience indicates that what must happen during the years to come, according to Dr Phillips, is a greater awareness of alcohol abuse. In an era when most groups in society are becoming more health conscious and interested in the prevention of ill health, the approach has more of a chance now than ever before.

"But it will take a few years to sink in and motivate the individual to live more responsibly. In the meantime, we in the substance abuse field will have to continue putting major effort and resources into treatment.

"The shift toward successful prevention will come gradually."

It will come partly as a result of an open-communications philosophy between provincial substance abuse agencies such as AFM that is generally considered unique in the western hemisphere.

"We can't really understand why you would hoard information and guard it from other agencies as if you were in commercial competition. Yet that's exactly what is happening very frequently between agencies in many US states," Dr Phillips said.

Not only do Canadian anti-abuse organizations readily share information, they also share the best they have to offer in talents.

Last month, for example, a senior staff training official of the AFM, known for his accomplishments, was sent to Ontario to conduct a week-long staff training course.

Ontario experts have been across the country to teach and demonstrate. Alberta has also become known for this type of cooperation with other parts of Canada.

"And when you compare Canada with other countries, we are recognized as among the most progressive countries in the world in our approach to alcoholism and other substances," Dr Phillips said.

THC vs chemotherapy nausea

New Mexico to test cannabis therapy

WASHINGTON — Approval has been given by the Food and Drug Administration (FDA) for New Mexico officials to test marijuana on cancer patients in an attempt to ease nausea associated with their chemotherapy.

The state-run program will compare marijuana's effectiveness with other drugs now being used. New Mexico is the first state to begin a research program, although three other states have applied to the FDA for permission for similar research.

New Mexico officials intend also to use marijuana for glaucoma patients. This program has been delayed because the doctor who was to supervise it is leaving the state and protocols are still being hammered out with the FDA.

Edward Tocus, PhD, chief of the drug abuse staff of the FDA's bureau of drugs, said the FDA prefers to see oral use of tetrahydrocannabinol (THC) rather than smoke marijuana "because the plant material varies enormously. Even the government grown material varies all over the place.

"With an oral dose we know exactly what is given."

One problem he has found with oral THC use is erratic absorption by patients, according to Thomas Ungerleider, neuropsychiatric institute, University of California, Los Angeles. Dr Ungerleider is currently carrying out trials of THC and an antiemetic in a double blind study among cancer patients.

Dr Ungerleider told the annual meeting of the National Organization for the Reform of Marijuana Laws (NORML): "Some of our patients who receive oral doses of THC are still nauseated during the day and then wake up at midnight stoned out of their minds. We have found in some cases with smoke marijuana you can get good absorption."

Dr Ungerleider said the results of the trial with 200 patients have yet to be analyzed, but it appears marijuana will help some people who cannot be helped by conventional therapy.

He noted: "There are a lot of other conditions where marijuana has been used but there are other drugs that are better, and you can't make a case for its use so far. We are investigating it as a broncho-dilator, for anti-bacterial activity, and for retardation of tumor growth, and in the treatment of drug dependent people.

"I think there is a lot still to be done."

In lab of Britain's new drug control and teaching centre at London University, pharmacist Arnold Beckett plans for special research on drug abuse in sports.

Drugs in sports: 'A new era'

LONDON — The British Minister for Sport, Denis Howell, has inaugurated a new drug control and teaching centre at Chelsea College, University of London, which is regarded here as opening "a new era in the control of drug abuse in sport."

The centre is being funded by the Sports Council at a rate of £25,000 a year for three years, and will be headed by Professor Arnold Beckett, pharmacist and member of the International Olympic Committee's Medical Commission.

Professor Ray Brooks of London's St Thomas's Hospital, who is well known for his work on screening for anabolic steroids, will work jointly with Professor Beckett.

Britain is the first country in the world to set up an international testing centre independent of the Olympic Games.

Professor Beckett told The Journal he believed Britain now has a unique opportunity to develop an overall policy for drug control in sport. He said he believes cases reported in the national press were "just the tip of the iceberg." There was little room for complacency and the only deterrent was compulsory random testing in all branches of sport, coupled with further research.

The centre would provide testing facilities for sporting organizations and act as an information and training centre. It would also pursue research into drugs used in sport and techniques for detecting them.

Chelsea College, Chelsea Manor Street, London SW3 3TW. Tel: 01-352-1472. (Centre phone, Tel: 01-352-3838)

Contact with West brings hard drinking to South Africa Zulus

LONDON — A study of a predominantly Zulu township 12 miles north of Durban, South Africa, has shown that contact with Western civilization increases the rate of problem drinking.

So reports social worker Heather Snidle in the *British Journal on Alcohol and Alcoholism* **(Vol 13, 3, 1978).**

Ms Snidle, lecturer in social work, University College Cardiff, Wales, notes drinking alcoholic liquor was interwoven with Zulu social custom; yet the traditional culture was in a state of disintegration and the Bantu had to make much social adjustment to cope with the rapidly developing industrial society.

Owing to governmental regulations and the influence of missionaries, beer was no longer drunk to the same extent as formerly.

But the problem of alcoholism had been obscured by the inability to distinguish it from social drinking and drunkenness.

A treatment centre was set up in the township, Kwa Mashu, and a sample of about 100 adults with drinking problems subsequently compared with a similar group for whom alcohol was not a problem.

Although the majority in both groups came from rural areas, 40% of the alcoholic group were urban Bantu whereas only 6.2% of the control sample were. The alcoholics tended to be better educated and to have only a low percentage of unskilled workers.

Ms Snidle reports that total abstainers among the township adults were usually Bantu Christians, drinkers were mostly "ancestor worshipers," and alcoholics were predominantly members of churches of Western origin, notably Methodists.

It appeared the incidence of problem drinking was very high — 15.5% in the drinking population and 7.2% in the adult population living under family conditions — whereas the percentage of compulsive drinkers was even higher, at 17.8%.

Although all the alcoholic sample admitted problem drinking, a small percentage blamed this on witchcraft. Half the population of Kwa Mashu were living below the breadline and many suffered from malnutrition as well as alcoholism.

Alcoholics require more anesthetic

CHICAGO — Alcoholics require about a third more anesthetic agent during surgery than non-alcoholic patients.

This report here, to the American Society of Anesthesiologists, for the first time put a definite figure to the "common clinical wisdom" among anesthesiologists, which has long noted that alcoholics can't be "put to sleep" as easily as non-alcoholics.

Richard E. Barber, University of California School of Medicine, San Francisco, told of quantifying the actual need for the anesthetic gas, halothane, in 11 normal, and 14 alcoholic, patients. The alcoholics were defined as individuals who consumed at least a pint of whisky, or its equivalent, each day for at least 10 years. The 14 alcoholics, Dr Barber said, "had all suffered withdrawal symptoms on one or more occasions, and most had abnormal hepatic function tests consistent with the diagnosis of alcohol-induced liver damage. In contrast, the normal patients drank very little, or not at all — at most, two to four drinks a week."

None of the patients in the study, who were undergoing a variety of operations, was taking any medication which would change the anesthetic requirement, Dr Barber said. None of the patients had any muscle relaxants given with the anesthesia. All breathed spontaneously, under the halothane anesthesia, for at least 10 minutes before the skin incision was made.

The first patient in each group was then given the estimated standard dose of halothane.

"If patient movement was noted in the first minute after skin incision, halothane concentration for the next patient in the group was increased by 1/10%. If no movement occurred after skin incision, the halothane concentration for the next patient in that group was decreased by 1/10th%."

This study of when movement occurred, he added, indicated that in the alcoholics, it was 44% more often than in normals, which was a highly significant figure. In individual alcoholics, who drank much more than the minimum required for the study, the difference was even greater.

A problem with the alcoholics' increased need for an anesthetic during surgery is that such a need could have an adverse effect on the cardiovascular system. However, Dr Barber said this factor was studied retrospectively, rather than prospectively, so the adverse effect, if any, is not proved. "We were concerned that cardiovascular function in the alcoholic patients might be considerably, perhaps dangerously, more depressed than in their normal counterparts." While a retrospective look showed that their systolic blood pressure was decreased somewhat more, this was not a significant difference.

"I would rather say that we thought of something after the fact, gathered incomplete data in the retrospective fashion, and were unable to tell whether there was any difference between the two groups of patients in their susceptibility to the cardiovascular depressant effects of halothane."

Smoking cut in US plants

WASHINGTON — New safety standards for industries in which tobacco smoking could increase workers' chances of developing occupational diseases, are being drawn up by the American government.

Restrictions will be increased on certain companies unless they require workers not to smoke, according to Joseph Califano, secretary of health, education and welfare. Cigarette smoking is implicated in increased risk of disease where a worker is already exposed to a hazardous substance.

Among asbestos workers, for example, the risk of contracting lung cancer is three to four times higher among smokers, and 92 times higher than among non smokers who do not work in the asbestos industry.

Lilly says drug has history of safe use

Darvon: 'Deadliest Rx drug in US'

WASHINGTON — A careful review of the pain killer propoxyphene (Darvon(R)) is being made by the Food and Drug Administration (FDA) following claims it is an "imminent hazard" to health.

The FDA moved after Sidney Wolfe, director of Ralph Nader's Health Research Group, called for either a ban or much tighter controls on prescribing. In 1977 doctors wrote 35.5 million prescriptions for the drug worth $140 million.

Dr Wolfe said figures issued by the Drug Abuse Warning Network (DAWN) showed propoxyphene was related to 589 deaths in 1977.

Dr Wolfe said the drug has little value in easing pain and it is no more effective than acetylsalicylic acid.

He described propoxyphene as "the deadliest prescription drug in the US" and its use "is tantamount to legalized dope."

A recent FDA publication said the majority of deaths associated with propoxyphene occurred in patients with histories of suicidal tendencies, emotional disturbances, or misuse of alcohol, tranquillizers, or other central nervous system depressants.

A spokesman for Eli Lilly, the principal manufacturer, said the drug has a long history of safe and effective use. It's been on the market 21 years.

The drug is not immune from misuse, the spokesman added, but hundreds of millions of patients had taken billions of doses with an extremely high ratio of safety and relative freedom from side effects.

Earlier in 1978, the FDA ordered the company and other manufacturers to warn doctors that propoxyphene overdoses can cause coma or death, and the drug should not be taken with alcohol or tranquillizers. In 1977, the drug was put on schedule IV of the controlled substance act, which limits prescription refills to five within six months.

Dr Wolfe said that when the drug was introduced it was called a "non-narcotic" and this had confused doctors, who are slow to change prescribing habits. Scheduling the drug had done little good.

The National Institute on Drug Abuse said a study in 24 major American cities between May 1977 and April 1978 found propoxyphene implicated in 486 deaths. During the same period heroin was implicated in 609 deaths.

Drug abuse up in schools

VANCOUVER — Drug use continues to climb in city schools here.

A survey prepared by British Columbia's alcohol and drug commission for the school board finds 78% of the students use alcohol, and 47% use marijuana, up from 60% and 39% respectively in 1970.

Cocaine made a first appearance with 8.5% reporting at least one use.

Tobacco use was up to 72% from 43%.

The use of other drugs remained constant within a per cent or two. The 1978 figures: hallucinongens, 19%; non-prescription stimulants, 15%; inhalants, 11%; non-prescription depressants, 9%; heroin, 2%.

Tobacco, inhalant, and heroin use was greatest among students between 15 and 16 years of age.

Free heroin maintenance?

VANCOUVER — Former British Columbia appeals court judge Angelo Branca says he favors free maintenance doses of heroin for addicts to remove the drug from the black market.

"That is my personal opinion," he told The Journal. "I know the idea has a following, but I don't know by how many in the legal profession."

Mr Branca, now retired from the bench but back in private practice, says "something's got to be done. The police have failed, the courts have failed. Even a partial success would do a hell of a lot of good if it stopped shoplifting and addicts getting into schools to find more addicts . . ."

He said as soon as one pusher is caught "there's another to take his place."

Mr Branca said he "really doesn't know" at this stage whether proposed compulsory treatment to be introduced by the provincial government this year will be workable "but anything at all that has some chance of success is preferable."

Meanwhile, after another moment of wavering, the BC Medical Association is officially supporting compulsory treatment.

Doctors were worried early in November they might be legally liable for assault if they examined an addict brought into the compulsory system against his wishes.

However, Health Minister Bob McClelland assured the British Columbia Medical Association board the decision to commit addicts to the program will be made by the Supreme Court, and not by an assessment panel of doctors.

He said doctors will only be on the panel to diagnose suspected addicts.

'No panic' in Manitoba's seven-week liquor strike

By Manfred Jager

WINNIPEG — Liquor became very hard to obtain during a seven-week strike of Manitoba government liquor store workers this fall. Yet, there was no panic after it dried up completely.

Don Lang, director of alcoholism services at the Health Sciences Centre in Winnipeg, said in an interview there was evidence alcohol abuse actually went down in this city of 650,000 people as spirits became unavailable.

What's more, there was no evidence that alcoholics were using other substances such as cleaning fluids, vanilla extract, or strained leather preservatives and shoe polish to satisfy their craving, then getting sick and requiring hospital admissions.

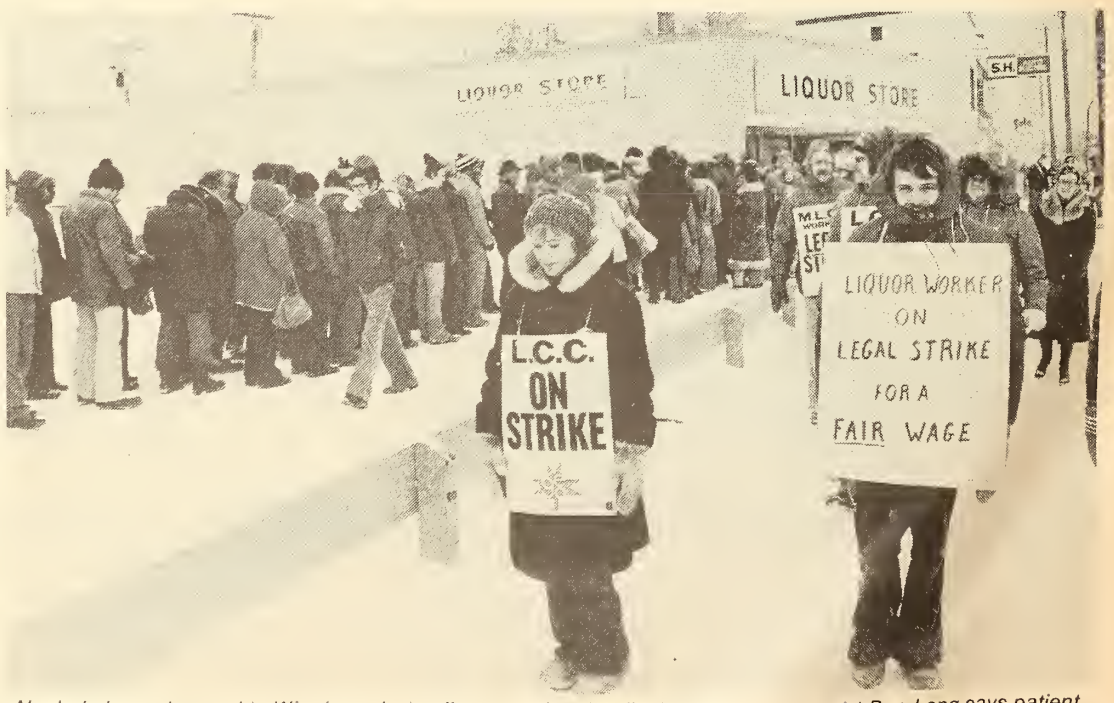
Dr Lang, a psychologist, said there was an average of five patients in his hospital's chemical withdrawal unit during the strike, down from about 15 on the average day before the liquor workers went on strike.

Total capacity of the withdrawal unit is 16, but one bed is generally kept open to provide for an emergency admission.

The 21-day recovery program of the alcoholism treatment unit in the hospital, part of the chemical withdrawal unit and located adjacent to it, continued at its full capacity of 24 during the strike, Dr Lang said.

"There are a number of patterns that could have something to do with the decrease in our admissions," he said. "The Main Street (skid row) strip was very quiet during the strike — probably partly because of the change of season. Also, the transients who don't want to stay in Winnipeg when it gets cold had left by then or were in the process of leaving. The alcoholism treatment facility near here was down dramatically in its patient load as well."

Dr Lang said patient demand became so light that five of the chemical withdrawal unit beds could be set aside temporarily for psychiatric admissions.



Alcohol abuse dropped in Winnipeg during liquor workers' strike last fall. Psychologist Don Lang says patient demand also was down in alcoholism treatment unit of Winnipeg's Health Sciences Centre. Photo: Winnipeg Free Press.

Smoking stunts children's growth—before birth

By David Milne

CHICAGO — For the first time in humans, it has been shown that smoking during pregnancy damages the fetus.

The damage consists of several alterations in blood vessels, according to Danish cardiologist Inger Asmussen. The blood vessel changes are identical to those in atherosclerosis experimentally produced in animals.

"The implications are clear," Dr Asmussen said. "Primary prevention of atherosclerosis must take place early in life. With regard to smoking, prevention should start in pregnancy before the child is born."

She reported her results at an international symposium on Primary Prevention in Childhood of Atherosclerotic and Hypertensive Diseases. Dr Asmussen studied the placentas of 15 non smokers and 13 smokers. All women had normal pregnancies and delivered normal, apparently healthy babies. All of the women studied were normal, healthy, and had no symptoms connected with the development of atherosclerosis. None had symptoms associated with excessive smoking.

Examination of the placentas of mothers who smoked revealed severe damage to the umbilical arteries and veins — the vessels that take blood to and from the fetus during its formation — while those of non smokers had none. The damage occurred mainly in the inner and middle layers of the vessels — the same layers affected by early atherosclerosis. The more the mother had smoked, the worse the damage.

The placentas of smokers were also more fibrous and had a poorer blood supply than those of non smokers. Babies born to the smokers were 10% smaller than those of the non smokers, a trend documented in past studies. The placentas of mothers who smoked were also 20% lighter. There were more female babies born to the smokers.

Dr Asmussen said she began her studies out of concern for people in their early 20s whom she saw die of heart disease. "It's really hard to watch a younger person dying of these diseases, and we've seen more of it in recent years," she said.

She believes in prevention and urges doctors and midwives to advise pregnant women to stop smoking. Can a women quit smoking during her pregnancy and thus save her baby from damage? Probably not, says Dr Asmussen. Damage to the fetus is dose related. If a woman has smoked during pregnancy her child will already have some vessel damage which will increase as the child matures. The result may be heart attacks, though not always fatal, in young adulthood. Her study demonstrated for the first time in humans what had already been evident in animal studies.

Dr Asmussen's answered critics who say her evidence is only presumptive, and not based on examination of the actual blood vessels of the children of mothers who smoke: "It is impossible to obtain definitive evidence in an ethical manner from a living child. But when severe damage is found in the blood vessel of the mother leading to the child as well as in the vessel conveying the blood back to the mother, it is reasonable to conclude that the vessels in between are damaged too."

Smoking does damage a mother's health, and even the health of her unborn child — this was one message of the recent Health Education Council anti-smoking campaign in England.

Drug workers must guard integrity

Battle on patients' secrets

By Jean McCann

CINCINNATI — Professionals treating drug addicts and alcoholics must resist attempts to breach the confidentiality of patient treatment records.

Attorney Dwight Tillery, assistant professor of law, University of Cincinnati, told a regional conference on substance abuse here: "If clients come to us, and we tell them that what is shared between us is held in confidence, and we begin to fork over those records to courts dealing with marital problems and custody problems and other issues, it will have a tremendous deterring impact upon those who seek our services."

When a record is subpoenaed despite workers' efforts, this action "must be resisted at all costs. I believe that your attorney must go to court with the intent of preventing the court's obtainment of the record and, certainly, at the very least, force the court to show an absolute need to get that portion of the record which is germane to the legal matter being litigated."

Mr Tillery said that, theoretically, the United States Health, Education, and Welfare department regulations do provide for confidentiality of patient records. The problem is that there are exceptions to this general rule.

'A big loophole'

For instance, a client's record can be disclosed with his written permission, but it can also be disclosed, without his consent, in case of a medical emergency, or "to qualify personnel for purposes of conducting scientific research, management audits, financial audits, and program evaluation," even though "such personnel may not identify either directly or indirectly any patient performing any of the aforementioned tasks."

A big loophole in confidentiality is also provided because the prohibitions do not apply to Armed Forces or Veterans Administration records.

Another part of the regulations, Mr Tillery continued, "says that if the court orders the releasing of a patient's record, there must be a showing of good cause, and the court must weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services."

In addition to the national laws and regulations, Mr Tillery said the state laws with regard to confidentiality must also be considered, and these may vary widely.

Rights of minors

Mr Tillery also discussed parental consent and the rights of minors to treatment.

In general, "if the law does not provide for treatment of a child without the parent's consent, then you should not treat the child without ascertaining that consent."

On the other hand, the parent or legal guardian is not financially liable for a minor's treatment, if he or she did not give assent to it.

Touching on another legal question, Mr Tillery said he believed treatment facilities generally are obliged to treat patients who come for help, "unless there is enormous documentation why that patient should not be treated at that facility. Furthermore, I believe you have an obligation to refer that patient to another source where he or she can be treated."

NB drug centre swings into action

By John Carroll

FREDERICTON — The appointment of senior staff, the calling in of consultants, a determination to utilize all possible resources, and establishment of a major treatment centre, are the thrusts of the New Brunswick Alcohol and Drug Dependency Commission as it swings into action.

Recently, Commission Chairman G. Everett Chalmers announced the appointment of six people to the organizational structure.

These were: Edwin Thomas, Fredericton, executive director; Achille A. Maillet, Fredericton, director of education and prevention; Patrick Cain, Fredericton, director of personnel and administration; David McTimoney, Oromocto, coordinator of research; Wayne Weagle, Riverview, coordinator of employer assistance programs; and Aurele J. Doucet, Bathurst, coordinator of justice intervention.

In a recent interview with *The Moncton Times* and *The Moncton Transcript*, Dr Chalmers said: "We have a good commission, with excellent representation from across the province. We have the authority to bring in consultants, which we've already done and will do again in order to reorganize properly."

Dr Chalmers said the director of education and prevention would go beyond the hitherto "pot-shot" approach of the odd movie, lecture, and question period in schools.

"We're going to develop something more substantial. I think education of alcohol abuse should start right in the family. Countries where wine, beer, and liquor are more widely available have proper education through family, schools, and the social structure, so there is less tendency for people to become alcoholics. It seems that in Canada there are more binge drinkers. Proper education could help offset that."

He reiterated his oft-expressed belief in an element of coercion in dealing with rehabilitation, saying "I've been in favor of mandatory treatment from the beginning."

Dr Chalmers said the coordinator of justice intervention will deal with the courts, and with cases involving such alcohol abuse as impaired driving. In addition, a study of the Intoxicated Persons Act is in progress under Commission member Judge Douglas Rice of St Stephen, with a committee composed of RCMP, police, and Bar Association representatives.

One section of the act provides for compulsory treatment of any person apprehended for intoxication three times in three months, although a judicial hearing would be required in such cases.

The Ridgewood centre to be established in Saint John is being developed as "a credible place with credible staff." Advice is being obtained from the Donwood Institute in Toronto.

Male, female alcoholism ratio probably equal

Joanne Cowan McGuigan — Treatment differs for male, female alcoholics.

BATHURST, NB — If the many "hidden alcoholics" among women came out into the open and sought treatment, there would be a one-to-one ratio with male alcoholics, according to Joanne Cowan-McGuigan, coordinator of alcohol treatment services, New Brunswick Alcohol and Drug Dependency Commission.

Mrs Cowan-McGuigan told an information meeting of the NB Advisory Council on the Status of Women held here in late November there are just as many female alcoholics as male. Public edueation is needed to enable women to eseape from the double stigma of being both alcoholic and "morally degenerate" and to seek help with a clear conscience.

She asserted that the causes and the treatment of alcoholism differed between men and women.

Info needed to promote controls on drinking drivers

MONCTON — More programs to reduce public opposition to control measures on impaired drivers are needed, Everett Chalmers, chairman of the New Brunswick Alcohol and Drug Dependency Commission, told a symposium sponsored by the NB Safety Council.

Dr Chalmers said possible control measures to combat drinking drivers were a higher minimum drinking age, a higher minimum driving age, special licences for new drivers, and a substantially-improved driver-education program.

The ADDC Chairman said "of interest is that 48% of all drivers were 24 years old or less" in the statistics regarding alcohol-related offences. He suggested driving courses be given before issuance of a licence, that this could be restricted, that it could be lifted for alcohol-related offences, and that the legal minimum age for driving be increased to 18 from 16 years.

Many of the drinking drivers referred to by Dr Chalmers in his statistics had, he said, admitted to use of marijuana, barbiturates, and other drugs.

The responsibility for reductions in highway problems lies with both the government and the public. Dr Chalmers said the various control measures are only as effective as their enforcement and only through the use of more educational programs could public opposition to such measures be diverted.

"The government must accept responsibility for providing the kind of information the public needs in defining and possibly modifying its own attitudes. The public must be informed concerning the risks of impairment."

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Quit the archaic jargon, psychologist urges

It was with considerable interest that I read the viewpoints expressed in the 'Letters to the Editor' column of **The Journal** (Nov 1, 1978). These letters between Lise Anglin and Oriana Kalant of the Addiction Research Foundation of Ontario disputed whether "physical" or "psychological" dependence was essential in the formation of an "addiction." Such discussions are enlightening because they serve to illustrate the mess that we can get into by using terminology that is not only inappropriate, but downright misleading.

To begin with, the term "dependence" should be eliminated since it implies that drug seeking behavior is in some way different from any other pleasure seeking or goal directed behavior. The difference it implies is that the "dependent" person is somehow driven by a desperate craving — an irrational, soul destroying, inhuman compulsion to take a drug. The reality of the situation is that no evidence exists to indicate that drug self-administration is governed by different behavioral principles than any other behavior. The state of research in this area is sufficiently advanced that we would know of such differences if they existed.

The distinction between physical and psychological dependence is an old one and was developed at a time when it became apparent in the public mind that people would take drugs for reasons other than dread or fear of withdrawal. The classical distinction, and the one made by Dr Kalant is that if withdrawal symptoms occur, then the dependence was physical and if they do not, the dependence was psychological. It is becoming apparent that this distinction is no longer useful since chronic administration of an effective dosage of any drug will produce a physiological change when it is discontinued. The change may be so slight that it can only be detected by sensitive physiological measures, such as disruption of sleep patterns, or it may be violent and life threatening. In any case, it is incumbent upon the person who wishes to use the "physical-psychological" distinction to discriminate between which withdrawal symptoms he or she considers of sufficient intensity to rate a particular dependence physical. The distinction is a quantitative one not a qualitative one as the words imply. In fact, the distinction is entirely arbitrary and, to my mind, serves no useful purpose whatsoever except perhaps to instill in the mind of the user the false impression that he knows something about the subject.

In reality, the issue that Anglin and Kalant are discussing is "to what extent does fear of withdrawal motivate drug self-administration?" Kalant's answer is "not much." By using the words "dependence" etc they have succeeded in clouding the issue, not illuminating it.

I would like to call upon drug researchers and professionals to try to break their "dependence" on archaic and misleading jargon when they communicate with others and the public. The terminology which we now use developed at a time when we had a completely different emotive and cognitive appreciation of drug usage and today, when we should know better, we are perpetuating the errors and prejudices of the past. Even worse, these errors are masquerading under the guise of scientific reality.

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Drug-taking, not drugs, the problem

Re: Psychology root of addictions, (**The Journal**, Nov). A word is a word is a word. Certainly, Oriana Kalant has the right to use the word addiction in any way that pleases her. However, if the word is meant to communicate something, and if her logic is questionable, then one must challenge her use of the word. Let's review her reasons:

(1) Compulsive drug-taking occurs with both physical dependence and drugs which do not engender physical dependence. Compulsive behavior can also be observed in areas such as handwashing, work, cleanliness, television soap-operas, gambling, and love. While the concept of addiction may be used as a metaphor in these areas, we run the risk of the metaphor becoming a substitute for reality. The same happened to the metaphorical concept of mental illness.

(2) The majority of addicts lapse into use after the withdrawal syndrome has run its course. This doesn't obviate the significance of a fear of withdrawal; it does show that such a fear may be easily overcome or ignored. The human capacity for self-deception is not restricted to drugs. And, addiction is not the only — or even the major — reason for such behavior.

(3) Craving or desire for the drugs is not observed in cases of iatrogenic addiction (eg morphine used medically for analgesia). All of the cross-cultural and social-psychological research in this area demonstrates that the drug experience and its meanings are learned; the semantic link between "hashish" and "assassin" is an historical curiosity to the contemporary user in Western societies. I'm confused as to how this relates to addiction.

(4) Compulsive repetitive drug-taking precedes the development of physical dependence. Years ago, Gordon Allport pointed out that our reasons for beginning something are not necessarily those for continuing to do it. To the fabulously wealthy entrepreneur, the financial wheeling-and-dealing may be "functionally autonomous" of its original financial motivation. Physical dependence may well be a partial explanation of why compulsive drug-taking persists.

My feeling is that Dr Kalant does point to the "essence" of the problem of drug abuse, which needs no tortuous redefining of addiction. Her very valid suggestion is that we focus on the problem of the pattern of drug-using behavior. If we do this, we must, logically, overcome our predilection to focus on the drug itself; the problem is compulsive drug-taking, not "addictive drugs," and is the dangerous pattern of drug-taking, not the taking of "dangerous drugs." We might even focus upon compulsive or dangerous drinking, instead of the nonsense of a "distribution of consumption" model which presumes everything to be causally related.

In short, addiction arising out of physical dependence, is real. It is not the essence of our non-medical drug problems. Let's abandon this search for a notion of addiction that adequately conveys these problems. The exercise is both confusing and unnecessary.

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Stopping drug can cause seizures, hallucinations

Now it's the *low-dose* Valium abuse syndrome

By David E. Smith*

Diazepam (Valium(R)) a benzodiazepine with properties similar to diazepoxide (Librium(R)) is the most widely prescribed drug in the United States. Approximately 50,000,000 prescriptions for Valium are written each year. It is estimated that during a one year period, approximately 30% of American adults use a psychoactive drug at least once, with the benzodiazepines representing the majority.

Diazepam is prescribed for a variety of medical and psychiatric conditions, with anxiety relief, sedation, and muscular relaxation being its primary therapeutic properties. In the recommended dosage range of 5 mg to 40 mg per day, despite its widespread use, it has a relatively low abuse potential in contrast, for example, to the barbiturates where an overdose leading to severe respiratory depression and even death, is a major hazard. A pure overdose fatality with diazepam is virtually unheard of.

Unfortunately, many physicians believe diazepam has no abuse potential at all, particularly if kept within recommended therapeutic range, despite the medical evidence that a well established pattern of acute and chronic toxicity exists.

'. . . Investigators have described a withdrawal psychosis after cessation of long term use . . . '

For example, diazepam is a sedative-hypnotic that interacts with other sedative-hypnotics, including alcohol, and in combination, can produce a severe and life-threatening overdose. High doses of diazepam, at a level greater than 100 mg over a long period of time, can produce physical dependency, and abrupt withdrawal can produce grand-mal seizures similar in nature to withdrawal from other sedative-hypnotics with one major exception. The peak liability for a withdrawal seizure is at five to eight days with diazepam whereas with the short-acting barbiturates such as secobarbital, the peak seizure liability is at two days. We have treated high-dose diazepam with a phenobarbital substitution withdrawal technique and had no difficulty preventing seizures and other withdrawal sequelae.

In addition to the high-dose diazepam abuse syndrome, or the abuse of diazepam in association with alcohol, there has been growing concern about low-dose benzodiazepine withdrawal syndrome. In view of the fact millions of Americans regularly take this drug in the low-dose or therapeutic range, Dr Vernelle Fox discussed this low-dose benzodiazepine withdrawal syndrome in patients with a history of alcoholism. Other investigators have described a withdrawal psychosis after cessation of long term use of diazepam even at low dosages.

My associate, Donald Wesson, and I found that during the course of our sedative-hypnotic research and training activities, most physicians were unaware of low-dose benzodiazepine withdrawal syndrome. Most consumers were equally unaware of its existence.

One confusing issue is that often the patient is self-medicating anxiety and when the diazepam is stopped, the anxiety returns. In addition, many people take diazepam 10 mg to 20 mg at bedtime for sleep. As with all sedative-hypnotics, if they stop the medication after a long period of use, a rebound insomnia can occur although this symptom occurs much more often with drugs such as short-acting barbiturates. Neither of the above symptoms are the withdrawal sequelae we will describe.

'. . . Patients with a history of alcoholism . . . seem unusually susceptible to this . . . withdrawal syndrome . . . '

We conducted a clinical survey in an attempt to document the characteristics of this low-dose benzodiazepine withdrawal syndrome. In the dosage range of 15 mg to 40 mg of diazepam a day, we found 50 patients who had withdrawal sequelae on abrupt cessation from long term use of diazepam. Interestingly, 45 of these patients had a history of alcoholism, although they were not using alcohol at the time of their diazepam withdrawal. Often these patients were placed on diazepam for anxiety relief, insomnia, or muscle relaxation.

It is important to warn the prescribing physician that patients with a history of alcoholism, even though they are at the present time alcohol free, seem unusually susceptible to this low-dose benzodiazepine withdrawal syndrome.

Of the remaining five patients in our study of 50, none had a pre-existing history of alcoholism and all had taken diazepam in a 15 mg to 40 mg range for time periods in excess of a year. Upon abrupt cessation of the Valium, four had symptoms of a withdrawal toxic psychosis and one had a withdrawal seizure. The latter, a 37-year old priest who had taken 10 mg of Valium three times a day without dosage variation for approximately five years, ran out of the medication by accident and had a withdrawal seizure on the sixth day. The priest had used no other psychoactive drugs and was very surprised that such a withdrawal phenomenon occurred as he had religiously adhered to his doctor's orders.

'. . . Physicians should look for non-pharmacologic alternatives to treatment of . . . chronic anxiety . . . '

We also found that patients have this withdrawal psychosis after prolonged use of diazepam when they enter the hospital for medical or surgical problems of another nature and their medication is terminated. Often, neither physician nor patient recognizes the potentially damaging sequelae of such an abrupt cessation and we urge gradual reduction of medication in such circumstances.

In addition, it appears the greatest variable in the low-dose benzodiazepine withdrawal syndrome is chronicity of use. The longer period of time the medication is prescribed, the greater probability the patient will develop such dependence. We are uncertain as to why prolonged use of diazepam can produce such dependence, but research into the newly discovered benzodiazepine receptors in the central nervous system may eventually give us the answer: prolonged use of diazepam may induce such receptor sites.

We recommend periodic therapeutic holidays at a reduced or zero dosage level for approximately five days as a means of preventing or reducing dependence in patients that require this medication over a long period of time.

In addition, physicians should look for non-pharmacological alternatives to the treatment of symptoms such as chronic anxiety, including exercise and appropriate modification of lifestyle. Decisions, however, must be made on a sound therapeutic basis for we have found that with increased publicity about diazepam abuse, many physicians are going to the opposite extremes and denying their patients this medication, even when indicated. Or worse, they are abruptly terminating the drug and misdiagnosing the withdrawal sequelae. The following case demonstrates:

A 30-year old female had been on 10 mg of Valium four times a day for approximately 15 months and as a result of various life problems, began to accelerate her dosage. Her psychotherapist became concerned about her Valium abuse, felt the patient was becoming a Valium addict, and terminated her medication. She developed progressive anxiety and agitation and, on the fourth day, began developing visual hallucinations. The physician prescribed chlorpromazine (Thorazien(R)) for what he felt was psychotic symptomatology and on the sixth day, she had a grand mal seizure which was treated with intravenous diazepam at a Bay area emergency hospital. In this case, the physician erred by abruptly stopping the medication. Also, he misdiagnosed the withdrawal and mistreated the withdrawal psychosis with administration of chlorpromazine (Thorazine(R)) which lowers seizure threshold and increases the probability of a withdrawal seizure.

It is important then, with the widespread prescription of diazepam, that the prescribing physician be aware of dependence and be able to diagnose and adequately treat the withdrawal sequelae from diazepam when they occur.

Further, as with all medications, a therapeutic balance must be maintained between positive aspects and toxic aspects of the drug. Patients who require this medication for legitimate therapeutic purposes should not be denied it because a physician is uncertain or confused about the abuse potential. As with all drugs, we urge the physician to obtain information about toxicity of diazepam from documented medical sources rather than the general media which often present a one-sided, inaccurate view.

***(Dr Smith is Medical Director, Haight-Ashbury Free Medical Clinic, San Francisco, and a member of** The Journal's **Editorial Board.)**

Corrections

In the December, 1978 issue, it should have been noted that:

Tim Padmore, a Vancouver correspondent, wrote the Comment — BC heroin plan: 'Worst is to come';

Ron Hall, director of information services at the Addiction Research Foundation and author since 1975 of **The Journal**'s monthly column, New Books, will continue to be a member of the team in 1979;

and, the report on the status of women in Quebec, Sexism causes illness, appeared first in another form in *The Montreal Gazette.*

GILBERT

This is the first of a monthly column on science and other matters by Richard Gilbert, a scientist with the Addiction Research Foundation of Ontario since 1968. Dr Gilbert is also a City of Toronto alderman, a member of Toronto's Board of Health, and a member of the Board of the Toronto Western Hospital. His opinions are his own and do not necessarily represent those of the ARF.

Alcohol consumption will decline in 1979

Our troublemaking editor asked that I begin this series by making a prediction for the New Year. My prediction is in the title. Strictly speaking, it applies only to Ontario, for it's based only on Ontario happenings. But, trends in alcohol consumption in Ontario are similar to those in most of the rest of North America, and so I shall stick my neck out and say that alcohol consumption generally may very well decline in 1979.

Ontario residents aged 15 years and over now consume an average of close to 2½ gallons of pure alcohol each year. This is the equivalent of 700 drinks, a drink being 12 oz of beer, 5 oz of wine, 3½ oz sherry, or a 1½ oz shot of liquor.

Since 1945, when we each knocked back an average of 300 drinks, there have been four distinct phases in our alcohol use: (1) Consumption shot up for three years after the war, increasing at the rate of 50 drinks per person per year. (2) Then, for 23 years, there were gradual increases averaging seven drinks a year, taking us to a 1971 overall average consumption of some 600 drinks. (3) During the next three years alcohol consumption again rose at a furious rate, by more than 30 drinks a year, taking us to our present annual level of near 700 drinks. (4) Since 1974 alcohol consumption has risen very slowly, by less than six drinks a year. The average yearly increase in per capita alcohol consumption since 1974 has been less than one per cent.

There are five reasons for expecting that alcohol consumption will be lower in 1979 than in 1978:

1. *Money will be scarce.* Real disposable income will decline because most wage increases will be below the rate of inflation. People will have less to spend on alcohol and will spend less.
2. *Prices will go up, more than in recent years.* Alcohol is currently cheaper in real terms than it has been since 1975. The provincial government is strapped for money and will raise more from alcoholic beverage taxes and profits. Higher prices will mean that the reduced amount of money spent on alcohol will buy even less.
3. *Alcoholic beverages will contain less alcohol.* Table wine will be bought instead of sherry. Light beers will gain a larger share of the market.
4. *Fewer people will be allowed to buy alcohol.* The legal drinking age rose to 19 years on January 1, 1979.
5. *Liquor stores will be open less often.* Store clerks are likely to strike in an attempt to raise their wages from a current annual maximum of $13,845 a year to near the maximum for Brewers Warehouse counter clerks, which will be $20,051 on July 1, 1979.

All of these effects will be small — perhaps a ½% decline in consumption will result from each one — but the cumulative effect will be sufficient to overcome the current trend of very small increases in alcohol use. Thus the net result will be that per capita alcohol consumption in Ontario will decline in 1979. Whether this is a good or bad thing for our society will be the subject of a later column.

Next month:
Second-hand tobacco smoke

From: The Journal Vol 8, No 1 TORONTO, January 1, 1979

1979 – INTERNATIONAL YEAR OF THE CHILD

The right to affection, love, and understanding.

The right to adequate nutrition and medical care.

The right to free education.

The right to full opportunity for play

The right to a name and nationality.

The right to special care, if handicapped.

The right to be among the first to receive relief in times of disaster.

The right to learn to be a useful member of society and to develop individual abilities.

The right to be brought up in a spirit of peace and universal brotherhood.

The right to enjoy these rights, regardless of race, color, religion, national or social origin.

UNITED NATIONS DECLARATION OF THE RIGHTS OF THE CHILD

The Journal is published monthly by the Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Canada.

MD alcoholism 'environmental': Dr Glatt

By Alan Massam

LONDON — Despite the documented seriousness of the problem of alcohol abuse among doctors, a leading authority on alcoholism takes an optimistic view of the prognosis.

Max Glatt, consultant psychiatrist at St Bernard's Hospital, London, and editor of the *British Journal of Addiction*, told a recent symposium he regarded the problem as largely environmental — that is an occupational hazard — which might be prevented by better undergraduate education.

Doctors had good personalities and social stability and could make a good recovery from alcohol abuse once they faced up to the situation and accepted the need for help and continued support beyond the acute phase.

Dr Glatt said hospital admission rates for male doctors for alcoholism were 2.7 times higher than admission rates for non-medical Social Class 1 men.

From various statistics, it was clear the number of doctors with drink problems in Britain was considerable. A very rough estimate would put the number at between 2,000 and 3,000.

What might be much more important was the number of medical people who were alcohol misusers without, as yet, being alcoholics. This figure must be considerably higher.

"The number of enquiries coming from worried wives or partners of drinking doctors supported the existence of a real problem in the ranks of the medical profession, and one wonders how and why the profession has been able to ignore it for so long," Dr Glatt said.

He added that among many doctor patients, the most commonly named emotional factors were feelings of anxiety, tension, and subjective inadequacy in undergraduate days. They learned to "treat" such unpleasant feelings with alcohol so successfully that habitual repeat doses, on lesser and lesser provocation by anxiety-producing circumstances, seemed justified.

Overwork, coupled with high responsibility, and the emotional stress it engenders, was often a real factor.

Dr Glatt said most alcoholic doctors came forward or were pushed forward by long-suffering partners at a relatively late stage in their alcoholism, sometimes after attempting to "cure" themselves with drugs.

They seemed to find acceptance of the problem unpalatable possibly because the condition was associated with down and outs, extreme character weaklings, or incurable psychopaths.

The usual therapeutic techniques could be helpful, however, and many doctors had found great help from Alcoholics Anonymous. For those who fought shy of joining a layman's society, the Alcoholic Doctors Group in the UK had been "extremely helpful."

Dr Glatt said there were quite a number of examples of recovered alcoholic doctors who subsequently had rendered great service to their fellow sufferers. His optimism about the prognosis brought him to the conclusion that there was an over-riding need for prevention.

Medical students could be made aware that doctors formed a specially vulnerable high risk group. Such students might thus learn to avoid the habitual, unwise, and, in the long run, risky excessive use of alcohol which so often seemed to pave the way for misuse as a regular comforter for the rest of their lives.

Abuse of Alcohol Amongst Medical Practitioners. Proceedings of symposium obtainable at £2 plus postage from Medical Council on Alcoholism, 3, Grosvenor Cres, London SW1X 7EE (Tel: 01-235-4182)

Swedish program gains converts

Smoking rate drops steadily

CHICAGO — Sweden's ambitious program against smoking, now in its fifth year, is gaining converts annually.

In 1970, smoking rates for men began to drop, and now continue to fall faster each year.

Women also are smoking less, a trend that began two years ago.

And, except for snuff, sale of tobacco products has gone down each year.

Gosta Tibblin, professor of social medicine at the University of Umea, reported these results here at an international symposium on Primary Prevention in Childhood of Atherosclerotic and Hypertensive Diseases.

Sweden's three-pronged approach against smoking was stated by the Tobacco Commission in 1971:

- To cut cigarette consumption back to 1920s level.
- To freeze use of other tobacco, except snuff. (Snuff is permitted when used to wean smokers from their habit.)
- To give smoking a negative image.

To reach these goals the Tobacco Commission is pursuing three intermediate objectives.

One is that children born after 1975 will be part of a "non smoking generation."

This will be accomplished by educating pregnant women and mothers of small children about smoking and health.

Two is an ongoing health education program at each school level to reinforce an unfavorable attitude towards smoking.

Key adults in contact with children, such as parents of small children and health care personnel are encouraged to stop smoking.

Three is that market regulations on tobacco are used to support the program.

Although it has taken the bureaucracy three-and-a-half years to implement the proposals of the Tobacco Commission for control of the tobacco market, a national tobacco policy is beginning to take shape.

The next step will be a total ban on printed advertising, the most widely used method to promote tobacco sales in Sweden since there is no commercial radio or TV.

The Commission also plans to restrict smoking to designated public places.

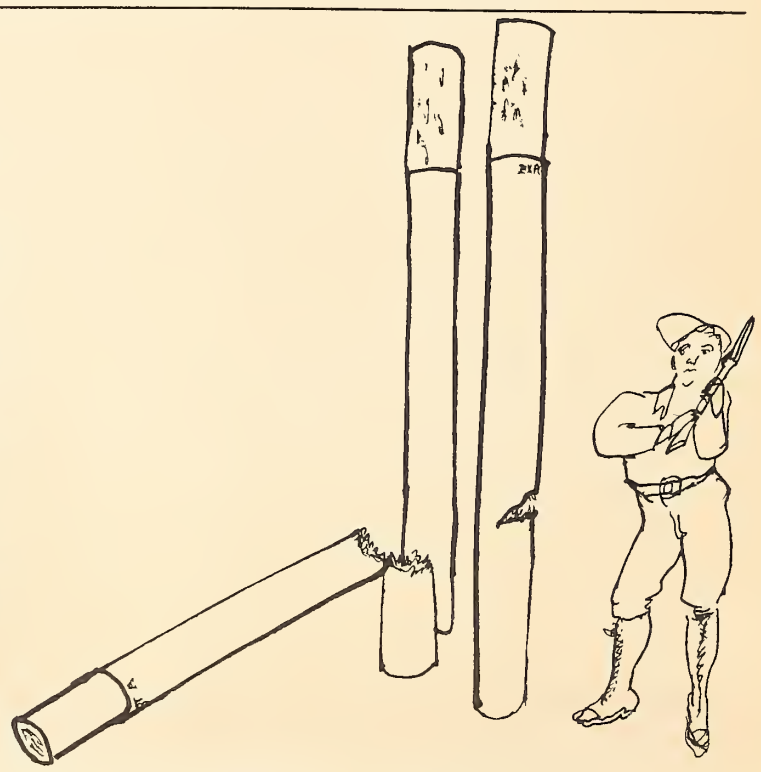
Dr Tibblin said that even under ideal conditions, the percentage of smokers in the total population will not begin to decrease until 1995.

In 2005 the first non smoking group will be 30-years-old.

But in the over-30 group, 26% to 28% will still be smokers.

He estimates that in 2005 more than one quarter of the population over 30 will still be smoking, which is enough to influence the mortality and morbidity tables for an additional 30 years.

A 25-year program has been proposed as the minimum period needed to achieve a definite change in the smoking pattern, he said.



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Crisis centre opens for London inner-city addicts

LONDON — After five years of campaigning — and many disappointments — field workers here have welcomed the official opening of a crisis intervention centre* for the capital's ever-present young polydrug users.

The £400,000 centre has been set up as a three-year experiment in a crumbling Victorian house not far from the Angel Islington, one of London's depressed inner-city areas.

It was officially declared open in October by Minister of State for Health Roland Moyle, whose department is providing the finance jointly with the London Boroughs Association.

But clients had already been using the centre for nearly five months. The objective is to provide an alternative to the hospital casualty department where poly-drug users have invariably ended up in the past. It was found that after treatment, addicts were merely returned to the streets to resume their rootless and hazardous lifestyle.

The new centre aims to provide sheltered accommodation with ready access to nursing, psychiatric, medical, and social work support, and is believed to be the first of its kind in Europe.

Support is available for up to 15 residents between the ages of 16 and 30 years to enable them "to identify longer term aims." After careful assessment, approaches are made on their behalf for longer term treatment, accommodation, and rehabilitation.

Each client is expected to stay in the centre for about three weeks.

A spokesman for the centre told **The Journal** that although it was too early to draw any conclusions, early indications were that the age range of clients would be wide, but concentrated around the mid-20s.

About 60% of clients were brought up in London so it was clear young people drifting in to the capital from provincial centres had not yet been reached to the extent that had been anticipated.

All residents had required substantial amounts of support and reassurance during their first day or so at the centre, but the calming influence of friendly and sympathetic human contact was preferred to the use of sedatives, the spokesman added.

Mr Moyle said Bob Searchfield, the first coordinator of the British Standing Conference on Drug Abuse (known as SCODA), was instrumental in highlighting the need for special facilities for young multiple drug misusers "some years ago," but it was not until 1977 the people developing proposals for the project could find suitable premises.

The Minister added that besides supporting the establishment of the centre, his department was also funding an independent research program through Birkbeck College, London University.

**City Roads (Crisis Intervention), William Hart House, 358, City Road, London EC1V2PY Tel: 01 278 8671.*

Gillain Manor...

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Dr. J. George Strachan, F.R.S.A., LL.D.

J. George Strachan, F.R.S.A., LL.D., founder and Executive Director of GILLAIN MANOR LTD., is internationally known and respected for his contributions to the care of the alcoholic. He is the author of Alcoholism: Treatable Illness, and Practical Alcoholism Programming.

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MP fires at tobacco promo

By Alan Massam

LONDON — Veteran campaigner for better health Laurie Pavitt, MP, has successfully presented a private Bill before parliament here which would give the Secretary of State for Health powers to control virtually all forms of tobacco sales promotion.

It is identical in form to legislation which was at the same time being introduced in the Dail by the Irish Government.

Mr Pavitt told **The Journal**: "This Bill challenges British health ministers to show the same determination as the Ministers for health in Ireland and 13 other countries which have already banned cigarette advertising.

"Cigarettes are still by far the country's largest avoidable cause of death and disease. It is appalling that the sheer political muscle of the cigarette industry has so far prevented our health ministers from taking the action they know to be necessary.

"If this bill is implemented it will ensure that the massive expenditure of cigarette advertising can gradually be brought under control."

Mr Pavitt, chairman of the all-party group of British MPs "for action on smoking and health" has called his bill the Tobacco Products (control of advertising, sponsorship, and sales promotion) Bill. It would provide for the control and regulation, including the prohibition, of advertising tobacco products — including sponsorship.

Mr Pavitt's Bill has already passed its first House of Commons hurdle by securing a first reading.

Meanwhile the government considers it is already achieving progress on the front of reducing the smoking health risk. Robert Sheldon, financial secretary to the treasury told the House at the end of November consumption of high tar cigarettes here (that is those rated at 20mg of tar or more) has been significantly reduced since the Tobacco Products (High Tar Cigarettes) Regulations were introduced two months earlier.

These regulations, which, in effect, put a higher tax on the high tar brands, had the effect of reducing their share of the market from 15% to 3%.

Mr Sheldon said: "There can be no doubt that smoking, particularly cigarette smoking, has an injurious effect on the health of smokers. The experts cannot be sure precisely how or why this happens, but they do know that smoking is responsible for many cases of a wide variety of unpleasant and painful diseases, such as lung cancer, bronchitis, emphysema, and heart disease.

"This causes much unnecessary suffering and many premature deaths. Detailed studies have shown that high tar cigarettes do more damage to health than low tar cigarettes."

NEW MATERIALS FROM ARF

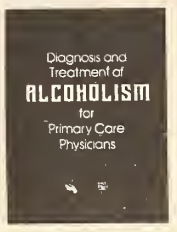
GUIDES

P-151 **DIAGNOSIS AND TREATMENT OF ALCOHOLISM FOR PRIMARY CARE PHYSICIANS** **$1.95**

A 36 page handbook on alcoholism developed for the primary care physician in conjunction with the Ontario Medical Association. A "how-to" guide dealing with identification, diagnosis, short and long-term management in both the medical and psycho-social senses. Invaluable to the medical practitioner.

P-160 **TEN LESSON PLANS FOR GRADES 7 AND 8** **$7.95**
P-161 **TEN LESSON PLANS FOR GRADES 9 AND 10** **$7.95**

The program consists of two sets of 10 lesson plans. Each lesson deals with a separate topic and can be used independently. Developed in conjunction with the Toronto Board of Education. The lesson plans provide the teacher with as much information concerning alcohol and the process of teaching about alcohol as is possible. Includes suggestions for A/V and other materials to enhance the program. The Ontario Ministry of Education has reviewed the lesson plans and found them to fit Ministry guidelines.



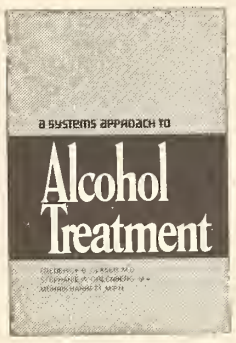
BOOK

A SYSTEMS APPROACH TO ALCOHOL TREATMENT

Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.

$14.95

A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



VIDEO CASSETTE

V-028 **MARIJUANA - THE FACTS** **$95.00**
25 Minutes, Color

Target Audience: Teachers, social workers, health professionals, and general audiences of mid-teens and older. Especially useful in learning or teaching situations.

Content: What is marijuana and what does it look like?
Is it addictive?
Effects compared to alcohol?
Does use lead to harder drugs?
Would use be beneficial for particular medical problems?

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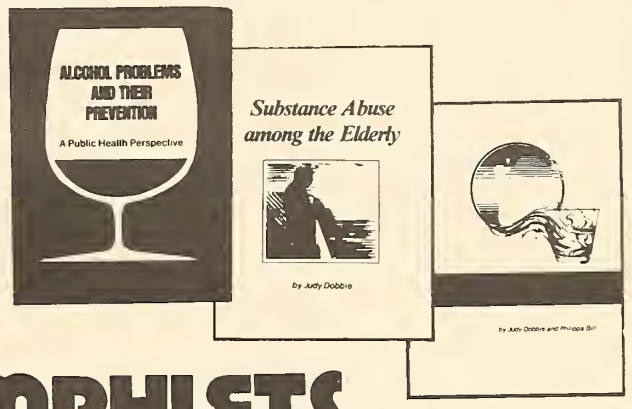
P-111 **ALCOHOL PROBLEMS AND THEIR PREVENTION —A PUBLIC HEALTH PERSPECTIVE** **40¢ each**



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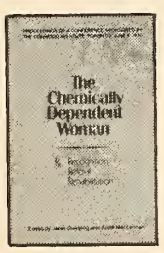

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THE CHEMICALLY DEPENDENT WOMAN

The published presentations resulting from a conference on women's issues, hosted by the Donwood Institute, Toronto. A distinguished group of presentors, including Dr. Gordon Bell and Ms. Jan Du Plain, address issues of usage, patient and physician perspectives, treatment trends, and new directions for women.

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SOLVENTS, ADHESIVES, AND AEROSOLS

The published presentations resulting from a seminar hosted by the Ministry of Industry and Tourism and the ARF on the use and misuse of these substances. The volume contains papers on historical review, legal considerations, community approaches to treatment, industrial perspectives, and a keynote address on international trends by Dr. Sidney Cohen of U.C.L.A.'s Neuropsychiatric Institute.

P-267 **$14.95**

INTERNATIONAL COLLABORATION: PROBLEMS AND OPPORTUNITIES

Proceedings of a two-day international seminar marking the designation of the Addiction Research Foundation as a collaborating centre of the World Health Organization.

Areas of discussion include: the epidemiology of alcohol and other drug-related problems, control strategies, and international collaboration in drug abuse programs.

Order by catalogue number from: **MARKETING SERVICES, ADDICTION RESEARCH FOUNDATION**
33 RUSSELL STREET, TORONTO, CANADA M5S 2S1
TELEPHONE: (416) 595-6056

New Books

by RON HALL

How To Communicate In Sobriety

. . . by Luther and Eileen Lord

Through illustrations and directives, this book explores the self-destructive personality characteristics of passivity and hostility. A description of reactions and feeling is provided for each of the characters (assertive, passive, and hostile) on topics including anger, criticism, judgement, God, and self-image. Passive-aggressive behavior is described and the relationship of these personality types is linked to drinking. Advice is offered on how to change behavior and the role of Alcoholics Anonymous is presented.

(Hazleden Books, Box 176, Center City, MN, 55012. 1978. 115p. $3.50)

Currents in Alcoholism — Volume III: Biological, Biochemical, And Clinical Studies

. . . edited by Frank A. Seixas

The format of this volume is intended to make it a yearbook of the biological, biochemical, and clinical fields in alcoholism, with introductions by distinguished members of those fields who chaired the concurrent tract sessions at the Eighth Annual Medical-Scientific Conference of the National Alcoholism Forum 1977. Papers are grouped under the following headings: animal studies and neurological findings; neurochemistry; causes and effects; metabolism of ethanol; three explorations of technique; pharmacological interactions; effects on the heart; parameters of alcohol actions on the body; alcohol and performance; diagnosis of alcoholism; and treatment and withdrawal. Among the significant highlights of the volume are a new animal model and a new treatment for hepatitis using propylthiouracil.

(Grune and Stratton Inc, 111 Fifth Ave, New York, New York, 10003. 1978. 621p. $31.50.)

Other Books

A Survey Of Treatment Needs Of Women With Drug-related Problems — Tetu, S., and Shore, D. Canadian Addictions Foundation, Vanier, 1977. Analysis of data from questionnaires distributed by four Ontario detox centres. Tables, bibliography. 33p. $1.25.

Women With Alcohol Problems And Their Treatment Needs In Ontario — Addiction Research Foundation, Toronto, 1978. A report prepared by the Working Group On Women Alcoholics for the Addiction Research Foundation Task Force On Alcoholism Treatment Services, March, 1978. Women in society, prevalance of alcoholism, characteristics of women alcoholics, treatment, services, barriers, recommendations, bibliography, tables. 65p.

International Survey — Brown, M. M., Brewers Association of Canada, Ottawa, 1978. Volume 1: Alcohol taxation and control policies. Part 1: International comparisons, governmental control, drinking patterns, alcohol problems. Part 2: Individual countries; Australia, Austria, Belgium, Canada, Czechoslovakia, Denmark, Finland, France, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Poland, Sweden, Switzerland, United Kingdom, United States, West Germany, Appendix, references. 306p. Volume 11: About beer; types, alcohol levels, regulations, composition, containers, production, exports, imports, mixed drinks, tables. 72p. $25.

Report Of A Survey Of Canadian Attitudes Towards Smoking — Data Laboratories Research Consultants, 1978. Commissioned by Weekend Magazine. Purpose, method and scope, results by regions, sex, age, income, language, national results, appendix, tables. 57p. $3.

The Alcoholic Marriage: Alternative Perspectives — Paolino, T. J., and McGrady, Barbara J. Grunne and Stratton, New York, 1977. Psychoanalytic concepts and the disturbed personality hypothesis, the decompensation hypothesis, sociological stress theory, application of learning principles to the alcoholic marriage, systems theory approaches to the alcoholic marriage, treatment implications. Index. 211p. $13.50.

The Care And Management Of the Sick And Incompetent Physician — Green, R. C., Carroll, G. J., Buxton, W. D. (eds). Charles C. Thomas, Publishers.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Jackson Junior High: Barbara Murray

Subject Heading: Attitudes and values.
Details: 15 minutes, 16 mm, color, sound.
Synopsis: A teacher, Barbara Murray, is asked by her students whether she drinks. She finds it difficult to state her views during a discussion on alcohol. A history of how alcoholic beverages developed, and how some different ethnic and religious groups drink is given. Later, on a date, Barbara refuses to drink although pressured by her boyfriend. Puzzled by her feelings, Barbara discusses her views with her parents. Back in the classroom Barbara is now ready to discuss her views.
General Evaluation: Good (3.8). The film was contemporary, and technically well produced. Its length was appropriate for most educational uses, and the film was considered an effective teaching aid.
Recommended Use: Likely to benefit audiences of 15 years of age and older. Particularly useful in teacher professional development.

Smoke Gets In Your Hair

Subject Heading: Smoking.
Details: 14 minutes, 16 mm, color, sound.
Synopsis: Fat Albert finds Wambly smoking in the janitor's room. After school, Wambly shows off by blowing smoke rings. Rudy is impressed and takes up smoking. In a theatre, Rudy's smoking bothers the other kids and they try to stop him. As a result the whole gang is thrown out. Rudy and Wambly continue to smoke and get caught by Wambly's father who is a heavy cigar smoker. While watching Wambly playing in a baseball game, his father coughs so hard that Wambly loses his concentration, strikes out, and the game is lost. After the coughing fit, the father passes out. Wambly and his father decide to quit smoking.
General Evaluation: Very good (5.1). A contemporary, interesting, and informative film with a clear message, it was deemed an effective teaching aid. Its length was appropriate for most educational uses. The A/V Group liked what the film said about drug use. Public broadcast was recommended.
Recommended Use: Likely to benefit audiences of 14 years of age and under.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

Detox Training Program — Feb 5-9, March 26-30, April 30-May 4, Toronto, Ontario. Information: Mr G. Gooding, assistant to the coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

From Cell To Psyche Symposium — Jan 18-19, Toronto, Ontario. Information: Student Symposium Committee, Room 2141, Medical Sciences Building, Faculty of Medicine, University of Toronto, Toronto, Ont, M5S 1A8.

70th Annual Conference Of The Canadian Public Health Association — June 18-22, Winnipeg, Manitoba. Information: Mr G. H. Dafoe, Executive Director, CPHA, 1335 Carling, Suite 210, Ottawa, Ontario, K1Z 8N8.

United States

Alcoholism — The Search For The Sources — Jan 24-26, Raleigh, North Carolina. Information: Elaine Woody, Center for Alcohol Studies, University of North Carolina, Chapel Hill, NC, 27514.

International Conference On Treatment Of Addictive Behaviors — Feb 20-24, Taos, New Mexico. Information: M. R. Miller, PhD, University of New Mexico, Albuquerque, NM, 87131.

Cruising Medical Seminar On Alcoholism — March 2-13, "Statendam" sailing from Florida. Information: John A. Ewing, MD, Director, Center for Alcohol Studies, University of North Carolina, Chapel Hill, NC, 27514

Alabama School of Alcohol Studies — March 20-23, Tuscaloosa, Alabama. Information: Peter Balsamo, Director, Continuing Education in Human Services, University of Alabama, PO Box 2967, University, AL, 35486.

American Medical Society On Alcoholism — April 26-May 2, Washington, DC. Information: J. G. Chen See, MD, AMSA, 733 Third Ave, New York, MY, 10017.

First National "Women in Crisis" Conference — May 17-19, New York City. Information: Jane Velez, Conference Administrator, "Women in Crisis", 444 Park Avenue South, New York, NY, 10016.

Abroad

International Conference On Animal Models In Alcohol Research — June 4-7, Helsinki, Finland. Information: John David Sinclair, Research Laboratories of the State Alcohol Monopoly (ALKO), Box 350, SF-00101 Helsinki 10, Finland.

25th International Institute On The Prevention And Treatment Of Alcoholism — June 18-22, Tours, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

10th International Conference On Health Education — Sept 2-7, London, England. Information: The Conference Centre, 43 Charles Street, Mayfair, London W1X 7PB, England.

OUTLOOK 1979

Predictions for a new year in the addictions field from some members of The Journal's Editorial Board.

H. David Archibald
Executive vice-chairman
Addiction Research Foundation of Ontario

• A major problem in this field nationally and internationally is that the impetus of policy makers has run largely in the direction of delivery of services. Proliferation of treatment services is not going to solve the problems when you haven't developed the basic data base on which to build a legitimate and logical system for treatment intervention. Research must have top priority.

• Internationally, I see two or three things happening. On the negative side, there is a proliferation of heroin dependence. As one looks at the heroin traffic patterns that have emerged in recent years, there is a very considerable amount of heroin from South-East Asia coming into Europe. Around each city in Europe in which an international airport is located, there is the beginning of a heroin epidemic and you see this in cities in which there has been no heroin known in the past — Stockholm, Helsinki, Geneva, Frankfurt, and so on.

I see no good reason why Canada will escape this. Although heroin dependence is not a large scale problem in Canada, or not perceived as one at present, in the not too distant future I expect to see an increase in this particular problem and I think we should be alert.

Secondly, in countries around the world, there is a North American pattern of what we've called polydrug use, emerging, particularly among young people in large cities in South-East Asia which, historically, have not known a very large drug problem, at least, not in the North American sense of the term. And now they are developing large-scale problems.

On the positive side, in terms of intervention, I think one of the major developments has been the shift of attention away from straight suppression of opium growing, for example in the rural areas of South-East Asia, a policy superimposed on the east very largely by the western community. The approach now is to concentrate on developing alternative economic and health opportunities for the people in the regions. This is, I think, a very important development, perhaps one of the most important developments in recent years on the international front. It is the beginning of recognition of the importance of the people in these areas and of the fact that the drug problem is not going to be solved by the process of suppression, rigorous law enforcement, killing, and destroying, as has been promoted by many people in the past.

In this area, I'd like to see Canada, through its international aid program, give some attention to rural opium producing regions. It's a very reasonable kind of approach that seems to fit well within the general policy and priorities of the Canadian International Development Agency.

Dr Edward Senay
Professor of Psychiatry
University of Chicago

I think that in the United States, public support of drug treatment and drug research will decrease, perhaps precipitously, in the coming year. This is particularly unfortunate because I think the number of people needing treatment is not declining, and the kind of treatment they need is different from the treatment we've been giving the last few years.

Research may not be hurt much but it's likely the attempt to do something about inflation is going to mean that public support of drug treatment is going to diminish. What I wish would happen is that support in all sectors for treatment of drug abusers would increase so we'd be able to get people younger, and be able to create some new treatment methods that would be improved and fit, in a better fashion, the needs of the younger treatment population that we have now.

The support for endorphin research should be greatly increased. The possible significance of this is enormous.

The need for educating the public about the proper philosophy, that is, one that would view the health consequences of all drug use that would mean alcohol and tobacco just starting to get underway and just caught hold. It'll certainly be unfortunate if the momentum of that particular philosophic thrust gets lost because of the downturn in public support. The private sector, hopefully, will become more involved, although that's not likely.

Dr Lionel Solursh
Associate Head
Department of Psychiatry
Toronto Western Hospital

Recreational substance use, with its attendant abuse, will continue in 1979. It is unlikely that any or many new substances will make an appearance. Cocaine will probably grow in popularity and other drugs or substances may swing in popularity. Multi-drug abuse, including alcohol, will continue. A few more governments will move to rationalize cannabis legislation, but the public at large, and politicians in general, will continue to express their dismay at recreational drug use and abuse and, in some areas, they and the police will adopt an overall hard line.

Research will continue in two fields at least. Treatment programs will continue to be found of limited value, whatever their orientation. Biochemical research will continue in the areas of pharmacologic effects, neurohumoural transmitter changes, and the development of various antagonists. Epidemiologic studies will continue within the limits of already tight budgets and reveal little. These studies will involve both legal and abused prescribed drugs.

Dr Reginald Smart
Associate Research Director
Research Division
Addiction Research Foundation of Ontario

As I look into my clouded crystal ball, I see only the following for the coming year:

• The British Columbia enforced treatment program for addicts will have endless legal and political troubles and will fail really to get started. Addicts will move away from BC to avoid the risks, thereby making it the first successful non-program.

• New ways of taking old drugs will be developed and become popular over night; others will be viewed as preposterous and no one will use them.

• Several new substitutes for narcotics will be introduced as painkillers and claims will be made that they are not addictive.

• Several old substitutes for narcotics thought to have been non-addictive will be shown to have addictive properties.

• **The Journal** will continue to improve and become a remarkable journalistic publication.

• Some of these predictions will turn out to be wrong.

Dr Albert Rose
Director
School of Social Work
University of Toronto

It is predicted that in 1979 the two substances which have been most used during the past three years, namely alcohol and marijuana, will continue to be the most widely utilized addictive substances.

Governments find themselves in a double bind with respect to the use of alcohol. In a period of economic constraint they are reluctant to give up the overwhelming tax revenue which the consumption of alcohol produces. In Ontario, where sales through government outlets will have exceeded $1 billion for the first time in the fiscal year 1977-78, the increase in 1979 may well be a further 20% to 25%.

At the same time, government restraints on expenditures may well mean that research in the field of addictions will be squeezed even further than it has been during the past years. While government might well like to reduce alcoholism and increase research into the causal factors, it is caught in this double bind of increasing revenues on the one hand and a push toward declining expenditures on the other.

As far as marijuana is concerned, it was reported recently that the total expenditures in the United States during 1978 will exceed $48 billion. This is a rough estimate of a trade which is considered to be illegal. Yet law enforcement agencies find it almost impossible to control the traffic.

Dr Thomas Ungerleider
UCLA
Neuro Psychiatric Institute

I think the drug abuse field is now in a period of disequilibrium following the "demise," if you will, of Drs Bourne, DuPont and Noble (**The Journal**, Dec, 1978). And I predict we will see more and more trial balloons sent up as vested interest groups compete for new territory, power, and money in this growth industry called the drug abuse industrial complex.

We see the head of the Drug Enforcement Administration entering the medical arena, quoted as claiming that marijuana is a greater cancer risk than cigarettes, citing the American Cancer Society and the American Medical Association, neither of whom have released corroborating data. The acting director (not a physician) of NIDA (National Institute on Drug Abuse) was quoted as supporting this crackdown on marijuana, and expressing his concern about adolescent marijuana *users*; but no mention anywhere of HEW's (the department of health, education and welfare) recently-released figures showing three million adolescents ages 14 to 17 *problem* drinkers of alcohol.

The Food and Drug Administration is proposing to ban amphetamines for *everything* except narcolepsy and hyperkinesis as their trial balloon to broaden their powers to regulate medical indications for all psychoactive drugs based on real or imagined drug abuse. We have these and other government agencies and politicians alike relying on the unvalidated, highly suspect, and often deceptively designed Drug Abuse Warning Network (DAWN) figures as an index of drug abuse trends.

The number of primarily heroin dependent people seems to have stabilized, but polydrug use seems to be increasing. Inexplicably, our government is not *vigorously* pursuing the one exciting development in combatting the heroin problem, namely depot (implanted) naltrexone.

The situation is not basically different from the way it was in the late 60s and early 70s when we "declared war on drug abuse." We still feature a drug of the month philosophy: now it's PCP or paraquat-laced marijuana. A few months ago, it was Quaalude. But the basic mentality is the same and, given that, I am pessimistic about the future.

The one good thing perhaps is that the problem, although it's just the same as it always was, is perceived as less of a problem by the public, and, therefore, there's less hysteria being generated by the various vested interest groups.

THE BACK PAGE

Dr David E. Smith
Medical Director
Haight-Ashbury Free Medical Clinic

The Haight-Ashbury Free Medical Clinic has been involved in drug epidemiology studies for a number of years. In the area of heroin epidemiology, our research director, Dr John Newmeyer, has been studying cycles of heroin addiction in the Bay area and found these cycles are predictors of nationwide trends. He has predicted both the up and down cycles of heroin use in the United States quite accurately over the last 10 years.

Recently, at a time in which heroin use has been going down all over the United States, we have seen in the San Francisco Bay area the beginning of another upswing. Therefore, I predict that within a year, the decrease in heroin use nationwide will bottom out and we will begin to see an upswing.

In addition, there is much more emphasis being placed now on a law enforcement approach to drug abuse and a decrease in funding both at the state and national levels for human services.

As a consequence, at the very time when greater need will be demonstrated for drug treatment, I predict there will be a concomitant reduction in treatment services available for the substance abuser.

Again, California is serving as a predictor in this area and, as a consequence of proposition 13, we are already beginning to see a reduction in drug treatment services which will escalate in 1979 as the state budget surplus is used up. In addition, the fiscal budget for the National Institute on Drug Abuse in 1980 contains a substantial reduction of funds for states which will also facilitate a drug treatment decrease. So we will be caught in the twin bind of having an increasing problem but a decreasing availability of human services to deal with this problem. This is, in part, a consequence of the more conservative anti-human service attitude that seems to be dominating in many areas of the US which, in turn, is a part of the rise of the new right in the United States.

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The Journal

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February Quote

There are only two lasting bequests that we can give to our children: one is roots, the other is wings.

Odyssey Institute, New York

'Split rationale' behind drug reforms

By Jeff Carruthers

OTTAWA — Justice Minister Marc Lalonde has made it official: bureaucrats in the justice department, health department, and solicitor general's department are reviewing on an "urgent" basis the country's existing drugs legislation, with a view to drafting reform legislation.

The resulting new legislation will once again attempt to "decriminalize" marijuana and hashish laws (at least lower the penalties for first offence simple possession of small amounts and perhaps eliminate the resulting criminal record) and fulfill a Liberal promise made some seven years ago.

(Sources in government reveal that while cannabis reforms are under study, so too are changes to make simple possession of amphetamines illegal, to move certain administrative powers relating to drug offences out of the health department, and to change powers of search and seizure given drug squads.)

While it is still not clear what decriminalizing of cannabis really means, and just how far it will go, both Prime Minister Pierre Trudeau and Opposition Leader Joe Clark say they are in favor of such action, though they warn that there are other, more urgent matters to resolve first.

Mr Lalonde, who as health minister failed to get a Senate version of cannabis reform legislation through the House of Commons in 1975, warns that while a new bill might be introduced early this year, there is little hope of it being passed before the election is called.

The Justice Minister has also revealed, through his comments, a split rationale behind at least the revived interest in cannabis reform.

In one interview, he said that "the drug culture has started to ebb in our society and, in a sense, it may be a good time to re-examine our laws in this respect."

The public, he suggested, is less traumatized now by the issue than they might have been a decade ago, when the drug revolution was at its peak. And while there remains concern about marijuana, "most Canadians now are taking a much more mature view of the problem than they could have then."

The oft-expressed fear that the country would turn into a society of drug addicts just hasn't turned out to be so, he suggested. And while drug addiction remains a problem, it hasn't spread as quickly as many had feared.

"So I think Canadians are more ready now to take a hard look at our laws and make sure that they are going to be respected and adapted to the values of citizens," Mr Lalonde said.

Which introduces the second rationale, "disrespect for the law."

In light of the tens of thousands of Canadians convicted each year for marijuana possession, it is clear that tens of thousands are just not respecting the law, he suggested.

"You have to ask yourself serious questions about that particular law and whether it is really responding to the values of the society in which you live and whether you can continue to have a law that is really rejected by such a large number of your citizens."

He expressed concern about inconsistencies and contradictions in various Canadian dangerous drug laws and noted it is not good, in terms of respect for the law, to have laws that can be shown to be inconsistent and illogical in offences and penalties.

Stressing that any changes might be more lenient in some areas and tougher in others, he said he would like to introduce legislation that would deal with a number of drugs and eliminate inconsistency in the treatment of drug offences.

MARC LALONDE:

Recent cannabis proposals — drug reform or law reform?

Comment by Jeff Carruthers. Page 8

Women prisoners drugged?

By Alan Massam

LONDON — One of the most influential pressure groups in Britain — The National Association for Mental Health — has called for a full public inquiry into the use of drugs in prisons.

The demand follows worrying allegations by consultant psychiatrist Tony Whitehead from Brighton, Sussex, that an unnamed women's prison in Scotland was using potent tranquillizers to control inmates.

"Either that or the number of psychotic patients at the prison is unbelievably high," he says.

Dr Whitehead's charge, which was published in the National Association for Mental Health's journal *Mind Out* is the latest in a series of unsubstantiated reports which Home Office undersecretary Dr Shirley Summerskill has described as "ill founded and based on distorted facts."

Dr Whitehead claims the Scottish prison has only about 150 prisoners, yet uses major tranquillizers on between 24 and 75 of them. The number of prisoners receiving anti-depressants or sedatives has not been revealed, he says.

"This rough and ready look at a prison's weekly supply of drugs would suggest that either there are very large numbers of psychotic prisoners, or that potent major tranquillizers are being used on individuals who are not psychotic as an instrument of control," he adds.

"If more information like this becomes available, it should be possible to convince even the most doubting that major tranquillizers are being used in British prisons for control and not treatment."

Calling for the inquiry, Tony Smythe, director of the National Association for Mental Health, said Dr Whitehead's observations were "a further piece in a very worrying jig saw puzzle." He said there should be a probe into all aspects of psychiatry within the prison service. Later, a Home Office spokesman announced Dr Whitehead's allegations were being studied.

That heroin plan: still more delays

VANCOUVER — More delays have been announced for British Columbia's troubled compulsory heroin plan.

Addict referral from the courts will not start until April 1, and police referrals — the main target of protest against the plan — will not start before July 1, at the earliest.

Police referrals had already been put off until April.

Only addicts taken over from earlier volunteer programs were in the program when it opened officially on Jan 1, and only volunteers will be taken for the first three months.

Bert Hoskin, chairman of the BC Alcohol and Drug Commission, blamed the delays on paperwork occasioned by changes made in the heroin treatment act last spring.

On another front, the BC Civil Liberties Association filed a Statement of Claim in their suit alleging the heroin law is unconstitutional because it infringes on a federal responsibility — criminal law.

The 13-page document also lists a number of other objections to the heroin law, including:

- **That the presumed addict is not given the evidence used to commit him;**
- **That he is not allowed to call on his own doctor for an examination;**
- **That the three-year mandatory treatment program is punitive.**

Global drug strategy urged

OTTAWA — Fighting drug abuse is as important a human rights issue as fighting racism, says one of the authors of a document on international guidelines for drug abuse control strategy and policies.

And the issue is clearly within the realm of responsibility of the United Nations in its "total effort against human degradation," Donald Smith told **The Journal**.

Dr Smith, a senior scientist in the International Health Services Division of Canada's department of health and welfare, is expected to be named chairman of this year's meeting of the UN Commission on Narcotic Drugs. He is now acting chairman.

He will present the document, which also calls for concerted international action to reduce demand for illicit drugs and suggests the media be enlisted to support the fight, at the commission meeting this month in Geneva.

INSIDE THE JOURNAL

- **Drugs and cults** — The Back Page
- **Soviet youth and alcohol abuse** — Page 10

RCMP support making speed possession illegal

Reaction to drug proposals mixed

OTTAWA — Superintendent Y. E. J. Beaulieu, the man in charge of the Royal Canadian Mounted Police (RCMP) drug enforcement branch, believes that making possession of amphetamines illegal will make existing drug laws more enforceable.

This is the reason why the RCMP is supporting such a move in a drug law review now underway within government, under the watchful eye of Justice Minister Marc Lalonde.

In some parts of Ontario and Quebec where "chemicals" such as illegally-manufactured amphetamines are a particular problem, police often find themselves helpless to do anything about obvious cases of abuse, because there wouldn't be sufficient evidence to support a charge of trafficking.

By the same token, Supt Beaulieu believes any government moves to "decriminalize" cannabis possession would be a move in exactly the wrong direction.

Decriminalizing cannabis — something both Prime Minister Pierre Trudeau and Opposition Leader Joe Clark say they support — "will make it like an accepted thing," Supt Beaulieu said in an interview.

Someone will still have to supply it, even though that will still be illegal.

Supt Beaulieu explained that he is not saying smoking a few "joints" is harmful, any more than shooting a small amount of heroin might be, to an individual.

But, he explained, the difference between cannabis and heroin, on the one hand, and alcohol on the other, is that the users of the drugs want to get as high as possible.

It's not like sitting down and having a glass of wine with supper.

Nationwide, the RCMP regard heroin enforcement to be the number one priority, followed by cocaine, chemicals, and cannabis.

On cannabis, he downplayed suggestions that "organized crime" is moving into distribution in any big way, such as in Ottawa, as some reports have suggested. One reason is that cannabis is too bulky and the risks of getting caught are higher than with other, more concentrated drugs.

At the same time, the cannabis "entrepreneurs" are quite organized in their own right and many are playing a lot tougher.

The use of paraquat on Mexican cannabis, to interdict supplies headed for the United States, has not really had a major effect in Canada. While there is little Mexican cannabis available, Canadian supplies have traditionally come from other sources anyway (such as Colombia and Jamaica).

The problem of illegal amphetamine manufacturing labs hasn't increased in recent years, though they are still as difficult to break up. Usually, the basic chemical work is done in a large city and the final (and illegal) stages done in a remote location, in a matter of days.

Making amphetamine possession illegal would help a little.

People with legitimate medical uses for amphetamines (and with legitimate prescriptions) wouldn't have problems under such a change, Supt Beaulieu maintained.

THC vs. conventional anti-nausea drugs: crucial experiment begins in Vancouver

By Tim Padmore

VANCOUVER — Doctors here have begun what should be a definitive test of the value of marijuana for relieving the violent nausea caused by cancer therapy.

After two years of requests, the British Columbia Cancer Control Agency has finally won federal approval to administer THC (tetrahydrocannabinol), the active agent in marijuana, in a double-blind experiment.

Crucial experiment

The pot is being compared to prochlorperazine, a conventional anti-nausea drug.

This is a crucial experiment, because the only other published study of marijuana as an anti-nausea drug (done by doctors at the Harvard Medical School) merely showed it effective compared to a placebo.

Is cannabis effective against chemotherapy sickness?

There is a wealth of anecdotal testimony that marijuana is more effective than conventional anti-nausea drugs — including the word of hundreds of BC cancer victims who take marijuana illegally when they are receiving courses of anti-cancer drugs.

But nausea is a tricky thing, explained cancer specialist Hulbert Silver, one of the principal investigators.

"I can probably make you nauseated just by talking to you and describing certain things." With something so strongly infleunced by psychological factors, it is essential to do a well-controlled experiment, Dr Silver said.

Patients are eligible to enter the trial if they have already had one course of anti-cancer drugs, and have gotten ill despite treatment with conventional nausea drugs. Dr Silver describes the conventional drugs as generally "not very effective" for this type of nausea.

If the patient agrees, he gets two more courses of cancer chemotherapy: with one course, he is given THC; with the other, the conventional drug. (Because the marijuana and prochlorperazine pills look different, the patient also gets a placebo version of the other pill each time.) Neither patient nor doctor knows which is which.

Dr Silver said it will probably take about six months to get enough cases to make the results statistically significant.

After that?

"I don't think there'll be any problem making the agent routinely available once it's proven effective," he said.

Should THC prove as effective as anecdote suggests, it will be a boon.

Added burden

Doctors believe patients' chances for recovery will be boosted. Days of not eating because of nausea weakens patients, and make them less responsive to anti-cancer drugs.

More to the point, to have to suffer days of nausea is an added burden for cancer victims. It is one reason why some cancer victims turn to quack remedies which offer painless, if ultimately ineffective, treatment.

HIGH TIMES: Book of tall tales

By Wayne Howell

Turn over in his grave. That's what Egerton Ryerson, the 19th century Methodist cleric and educator would do if he knew that the publishing house that bears his name (McGraw-Hill Ryerson) was importing into Canada a book entitled *High Times Encyclopedia of Recreational Drugs*.

This hefty 417 page volume which sells for $12.95 purports to be an encyclopedia; actually it is just a clever pastiche of articles culled from the pages of *High Times*, the commercially successful magazine that has been extolling the virtues of "recreational highs" for the past five years.

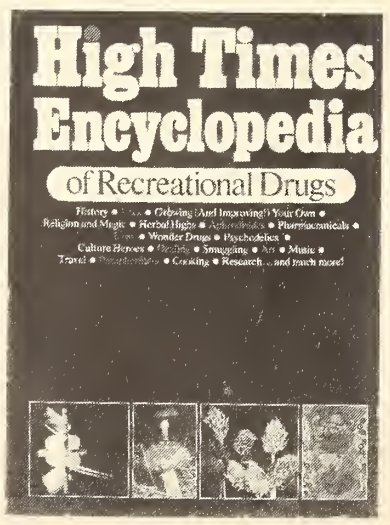
The *High Times Encyclopedia* is an important book for the simple reason that it will undoubtedly become a standard "reference work" for people who want information about drugs but who are not in the habit of reading pamphlets or booklets put out by such organizations as the Addiction Research Foundation of Ontario. Indeed, the "encyclopedia" has pretensions along this line, for it promises to provide the public with "access to unbiased intelligent information about the substances that they put into their body for pleasure."

Unbiased? The introduction to the encyclopedia states that the desire to get high is "the essence of civilization." This seems to be one definition of civilization that eluded the editors of my Webster's Dictionary: those poor fellows were of the opinion that civilization was (a) social organization of a high order, marked by advances in the arts and sciences etc, and (b) the total culture of a people, nation, period, etc.

Intelligent? An introductory essay suggests that the real source of the change in sensibility from the 60s to the 70s was the change from the "raw fresh energy of Mexican dope" to the "often immobilizing Colombian dope of the 70s". This seems to be an insight that has been missed by all the economists, historians, political scientists, sociologists, and cultural anthropologists who have commented upon the social and political changes of the last decade; it has even eluded Marshall McLuhan.

In all fairness, the encyclopedia does do a good job of outlining the history of drug use down through the ages, and in this respect the many illustrations from pre-historic times, classical times, and the middle-ages, give the book the appearance of one of those "History of Western Civilization" serial volumes that Time Inc is forever flogging through the mails. The text is witty, about as literate as you can expect these days, and for every bit of nonsense (ie — "following the ingestion of 500 micrograms of LSD you may relive your birth, return to the source of the evolutionary process, and become atomized into pure energy") there is an insight which, if not entirely original, is nevertheless arresting (ie — "what can more quickly set one above the common herd than paying outrageous sums for a subtle short-lived *unnecessary* experience? Snorting cocaine, in short, is the status symbol of the decade — the modern equivalent of feasting on the tongues of nightingales.")

The "encyclopedia" tends to wax rhapsodic about natural highs as opposed to chemical highs. Opium, for instance, is considered an okay drug because a poppy made it — the problem of narcotics addiction came about because of the hubris of man that produced such things as heroin and methadone. The implication is that we should not have tinkered with God's own Goodies. Getting back to nature can teach you a lot. Growing marijuana is, for instance, a positively enlightening experience: "You see the complete life cycle; from tiny seed (embryo) to seedling (baby) to vegetative stage (adolescence) to reproduction and, finally, to death, it parallels the human cycle. Almost every grower with whom we have talked has glowingly described the process as a most humanizing experience, one that has given insights into nature and the life processes." This is, apparently, not the kind of thing you can get from growing African violets in window boxes.



When it comes to documenting the dangers of certain chemical highs, the editors do not pull their punches — but they tend to hit with pillows rather than gloves. They do state that certain things can make you dead, but death is dealt with in such an off-hand manner (at one point in the section on barbiturates, death is referred to as "the ultimate high") that all perspective is lost. For instance, Methaqualone (Quaalude, Sopor), a drug with a formidable reputation as a respiratory depressant when combined with even moderate amounts of alcohol, is described as a drug that "gives a more euphoric vital kind of head than barbiturates," a "fun" drug that "can be ugly when used immoderately". I imagine this "ugly" business referred to is the "ultimate high" mentioned in the section on barbiturates.

If the success of the *High Times Encyclopedia* is anything like the success of *High Times* magazine, the encyclopedia is going to be read by a great many people: so let us hope that Reverend Egerton Ryerson was right, back in 1829, when he said: "Partial knowledge is better than total ignorance."

View clears on BC's heroin program

By Tim Padmore

VANCOUVER — Obscured by the dust of controversy surrounding British Columbia's compulsory heroin program, is what the program is actually doing to cure addicts.

While opponents say any treatment plan is likely to constitute more money down a familiar tube, backers have hailed the BC approach as the most sophisticated and complete ever.

Certainly there are ample resources: the planners expect to spend $15 million to $16 m a year to treat — at peak — 2,500 addicts. And a dazzling array of treatment options is being laid on, from biofeedback to marital counselling.

The alcohol and drug commission, which administers the plan, has been reluctant to grant interviews as the machinery comes on stream. But **The Journal** has obtained documents and met with sources that provide a fairly complete picture of what is being developed.

The basic aim is ambitious: complete abstinence from narcotics. That rules out the use of heroin substitutes such as methadone except during detoxification.

The keystone of the plan is contingency contracting. The hope is to emulate the moderate success enjoyed by a contracting program designed by Henry Boudin of the University of Florida. Some addicts in that program were under 'compulsion' having been referred to the program as an alternative to criminal proceedings.

Contracting means working out a detailed written agreement with the addict committing himself to abstain from drugs and to fulfil other requirements of treatment and supervision, such as phoning in several times a day to report "drug urges."

Success brings concrete rewards — $5 towards a TV set, for example. A violation brings a penalty — a forced donation to a hated charity, such as the John Birch society, is one suggestion.

The combination of immediate rewards and the longer term reward of successful abstinence are supposed to help prop up the personality of a typical heroin addict.

Mr Boudin, hired as consultant to the BC plan, says the contracting approach worked best with addicts referred by the courts, probably because they were forced to stay in treatment for a longer time than the average volunteer.

Other kinds of personality doctoring are being used. The list includes anxiety management, assertiveness training, family therapy, marital counselling, group therapy, life skills training, consciousness raising, and resocialization.

Physical needs are watched too: medical care for acute problems such as abscesses from frequent injections, nutrition, counselling, and exercise programs.

No therapeutic stone is being left unturned. Acupuncture, biofeedback, and hypnosis are among the more recherché alternatives. Megavitamin treatments have also been considered.

The intent is to cajole rather than coerce patients into treatments judged to be helpful.

"No attempt will ever be made to coerce individuals into any such program unless it is medically or psychologically indicated, and only then with the expressed and clear willingness of the client to participate," says a recent summary of the treatment set-up.

Facilities include the 150-bed detention centre at Brannan Lake on Vancouver Island, 11 community clinics around the province, a therapeutic community, a "special resource" centre, a street unit, and a behavioral therapy centre.

The first step for every addict will be a three-day evaluation at one of five area coordinating centres.

The basic purpose of the evaluation is to determine whether the person is "in need of treatment for narcotic addiction" and therefore liable to committal.

But the evaluation, which includes blood and urine tests for narcotics, personality tests, and medical and personal histories, also lays the foundations for treatment.

A detailed treatment plan is worked out after committal — either voluntary or court-ordered.

Very sick or very recalcitrant addicts will be sent to Brannan Lake for six months, or more, if a board of review agrees. Others will attend clinics on an outpatient basis.

As the client improves, supervision will be relaxed. Vocational training will be offered to give the client skills marketable in straight society.

And more than the addict is being cured, says the commission document.

"The Healthy Entry Plan offers the user something much better than an inescapable round of addiction, criminal activity, and imprisonment (and) offers our community something much better than the tremendous financial and social costs that have accrued from a disproportionately large heroin using population."

Mainly hits poor families

Fetal alcohol syndrome high in Yukon

By Sally Halliday

WHITEHORSE — The fetal alcohol syndrome — birth defects related to the mother's alcohol intake during pregnancy — is alarmingly high in the Yukon.

According to a British Columbia pediatrician who treats children in the Yukon during regular visits, the majority of the victims of the syndrome (FAS) are native children from poor families.

Kojo Asante, of Terrace, BC, says he has encountered at least 25 children in the past year and a half who suffer from FAS. This compares with 10 such FAS infants born to alcoholic mothers in areas of northwestern BC with similar populations.

"Although I don't see all the children in the Yukon, I am the only pediatrician in the area. And the numbers that have come to my attention appear to be greater than in other areas," he said.

Dr Asante stresses that FAS is not confined to poor people; however, about 85% of the children he has seen in the Yukon are native, from poor families.

"The ones who have been identified are the poorer people whose alcohol consumption is more widely known."

He offers a description of a typical mother who drank during pregnancy and whose child had birth defects:

"A teenage girl from a small Indian village more than 250 miles south of Whitehorse was at a party when she began to go into labor.

"She didn't known she was pregnant.

"A taxi was called to take her to the nearest nursing station, about 30 miles away, but the baby was born in the taxi.

"It was very small — one of the hallmarks of the fetal alcoholic syndrome — and was then taken to the airport to be flown to the Whitehorse General Hospital. The mother did not go to Whitehorse. She returned to the party, and the child died within a month."

Most of the surviving children who suffer from FAS end up in foster homes because of the problems of continued drinking by the mother.

Until recently, neither the mothers nor the medical staff in Whitehorse recognized the problem for what it was: fetal alcohol syndrome. Dr Asante says that only since he has been treating children on a regular basis has the pattern slowly emerged to allow FAS to be pinpointed. Birth defects that warn of FAS include cleft palate, brain dysfunction, jitters and irritability in the child, feeding problems, and low birth weight.

Despite the fact FAS is recognized, it continues to be difficult to prevent, he says.

Many native women do not visit their doctors during pregnancy.

Says Dr Asante: "Most mothers feel badly about it when they find out that their excessive drinking has caused birth defects in the child."

As for the high rate of FAS in the Yukon, Dr Asante relates the high level of drinking to the degree of isolation in the North, combined with the harsh climate.

"There are many bars in Whitehorse for the size of the town. It's just part of peoples' lifestyle, so they tend to drink more."

Dr Asante says he is now trying to publicize the problem (and provide information) to various groups in the small Yukon communities who are involved in alcoholism. "I have actually talked to mothers who stopped drinking because their first child suffered from fetal alcohol syndrome."

Pot becomes big business for US counterculture

TORONTO — The counterculture has moved into big business — selling millions of dollars worth of marijuana grown in the nooks and crannies of Hawaii and other parts of the United States. And it's largely the prohibition of pot that's lining their pockets with gold.

Special report

This was the conclusion of a recent special report in *The Atlantic Monthly* magazine on domestic marijuana growing in the United States, written by John Dowdy, a pseudonym.

Industry thriving

While most marijuana is still smuggled into the states, the domestic industry is thriving, the report said.

"This year the continental domestic marijuana market must account for at least $1 billion in retail sales, with another $400 million estimated for the Hawaiian crop.

"Over half of that money goes to the growers, thus ranking marijuana twentieth among the nation's cash crops and as the prime agricultural product of many counties."

Imports of pot and domestic cultivation are both on the increase, the report said, indicating that marijuana use is still moving into new groupings of Americans.

The report estimated from government confiscations of more than 900 tons of imported marijuana yearly,that Americans are smoking about 18 million imported pounds a year, plus millions of the domestic pounds.

Up fourfold

"At an average price to the smoker of about $30 per ounce, that's a $9 billion retail industry — still less than tobacco ($18 billion), but rising fast, and up fourfold or more from its 1974 gross of some $2 billion."

Radical shift

Investigating the economics of one pot-growing valley in Oregon, the report suggested legalization of marijuana could radically shift the economics of the counterculture, which is trying to continue educational and lifestyle practices of the 60s with the gains of pot growing.

Domestic marijuana growth

May detect organic causes of crime

Scan traces alcoholic brain atrophy

By Cora McCann

CLEVELAND — A brain scan may be used in the future to detect organic reasons for criminal behavior, including possible brain atrophy in alcoholic offenders.

A medical team addressing the International Probation Organization (IPO) here described how computerized axial tomographic (CAT) scans — telegraphic sweeps of cross-sections of the brain — might help.

"We would like to determine what relationship there might be between patients demonstrating psychiatric, drug, or alcoholic problems and organic brain damage," said Frederick Greenwald, president of the IPO and retired from the United States probation department.

"Can we rule out organic brain damage in any of these cases? Is it treatable on an out-patient basis, or is surgery required? What type of sentencing can best meet the needs of such a defendant and at the same time protect the community? Should the court rule that the defendant must submit himself to medical treatment as a condition of probation?"

If such questions could be answered, said Dr Greenwald, patients with organic reasons for criminal behavior might be spared the stigma of imprisonment.

Patricia Laffey, head of Non-Invasive Imaging at Hahnemann Hospital, Philadelphia, outlined her study of 5,800 brain scans performed there on in-patients and ambulatory out-patients. She was surprised at the high incidence overall of brain pathology in these patients but mostly, at the high incidence of brain atrophy in alcoholics.

Alcoholic patients between 30 and 39 years of age had a 63% incidence of brain atrophy, compared to 6% in the total series of patients in that age group. Similarly, in the 40 to 49 category, alcoholics had a 67% incidence of atrophy, and the total series showed a 14% incidence.

One slide displayed by Dr Laffey was of a 43 year-old alcoholic male's brain scan. The markedly dilated spaces in his brain revealed the presence of atrophy.

"Eleven years prior to this, this man slew his wife while intoxicated, and at the time of the scan was under indictment for slaying his brother during a drunken altercation.

"The high correlation of alcohol with a very high percentage of criminal violent acts committed annually in the US encourages the study of CAT scanning in diversionary programs. This can help identify hidden alcoholics or those who refuse to acknowledge their alcoholism, and make them more amenable to treatment."

Dr Laffey said that with conservative estimates at 10 million for identified and hidden alcoholics, brain atrophy must be fully investigated in terms of its dynamics and its natural history by the medical profession.

Use of the scan to study alcoholic brain atrophy has gained popularity since a recent study of alcoholics in Toronto found cortical atrophy could be reversed with abstinence, said Dr Laffey.

Robert Nathan, director of Liaison Psychiatry and Psychosomatic Medicine, Hahnemann Hospital, warned that further study of the correlation between violent behavior and abnormal brain scans would be necessary.

"The alcoholics examined by scan here were not a random selection, but were alcoholic patients who had sufficient signs and symptoms that the physician thought a scan was in order," Dr Nathan said.

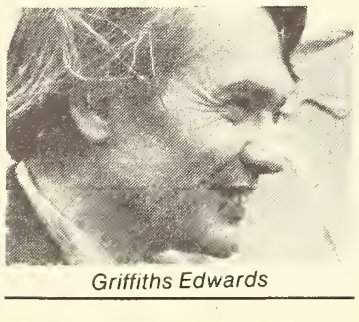
"In terms of the special utilization of the scan along with the psychiatric examination for probation purposes, we think we have something which can be very useful. But, rather than flying off on a wing and a prayer, we feel very obliged to urge for tightly-controlled studies to see what the relationship is between scans, psychiatric examinations, and offenders."

Fewer jobs could upset drug ecology

By Alan Massam

LONDON — High rates of unemployment, particularly among young people in Britain, together with unresolved difficulties in racial integration, provide the social setting which could lead to instability in drug ecology.

Thus, against the background of rising addiction problems in many European cities, British planners should now be considering the adequacy of drug policies.



Griffiths Edwards

This gentle hint for the Home Office here comes from Griffith Edwards of the Addiction Research Unit, Institute of Psychiatry, who writes in the *British Journal of Psychiatry* (Vol 134, Jan 1979) that a decade's experience of opiate addiction policies (since the establishment of government clinics for opiate drug treatment) does suggest some options.

Firstly, the notification system allowing for the establishment of the Home Office index of opiate addicts might either be abandoned as useless (because it does not reflect more dangerous misuse of non-notifiable drugs) or in some way strengthened.

Dr Edwards says the evidence points towards the latter option. Compulsory notification might be extended to include all cases where there is evidence of injected misuse of drugs, with an index which would thus give better indications of the 'exchange' between opiate and non opiate problems.

"Choice of injection as a key criterion would aid operational definition," he says, adding however, that notification would remain complete because only an uncertain and varying proportion of non-opiate users come to medical notice.

A much stronger case could be made for enhancing the impact of the index by strengthening the epidemiological research context, he goes on.

A monitoring system might be set up which could, at intervals, survey clinics, prisons, casualty departments of hospitals, and coroners courts, with the idea of focusing directly on matters of policy interest.

At present, not even the government's drug clinics are being surveyed regularly and could not, for example, provide information over time on variations in interval between first drug use and first clinic presentation.

Dr Edwards considers that the largest options for prevention might be the abandonment of the notion that the "competitive" provision of prescribed opiates (via the government clinics) limits the illicit market, and the strengthening of measures which control the supply of drugs to addicts.

He hopes this is not in the area of increased police or customs activity, but in further controls on medical prescribing. "If prescribing of barbiturates continues to be so lax as to breed serious problems, the question will inevitably be put whether the price being paid for the liberty of the prescriber is socially too great," he says.

On treatment, Dr Edwards says discussion on future policies is much handicapped by lack of information on what is actually being done and what is actually effective. The over-riding need, therefore, is for further clinical research which could intelligently guide the choice of options.

But "at least placed on the agenda" might be: to cease prescribing opiates to all new cases presenting at clinics so that their time and energies can be redeployed towards more positive efforts in treatment and rehabilitation.

British Policies on Opiate Addiction: Ten Years Working of the Revised Response and Options for the Future: Brit J Psychiat (1979 134, 1-13.)

Government index of drug deaths inadequate

LONDON — An investigation into the deaths of drug addicts in London has concluded not only that government monitoring of addiction fails to reflect the prevalance of the problem, but also that no single method of assessment can provide a complete picture.

A. Hamid Ghodse, consultant psychiatrist, St George's Hospital, Tooting, London, joined four researchers at the Addiction Research Unit, Institute of Psychiatry, London, to study 134 deaths in the age group 10 to 50 between January 1970 and December 1974, where drug addiction was recorded as the cause.

More than three-quarters of the addicts were under 30, and 105 (78%) were male; 55 (41%) were unknown to the Home Office.

Dr Ghodse and his co-workers note barbiturate overdose accounted for more than half of the deaths, though two thirds of these were registered as addicts to notifiable drugs (opiates).

They conclude that since the Home Office index (of drug addicts) covers addiction to one class of drugs only, it fails to reflect other serious forms of addiction.

The report, which appears in the *British Medical Journal* (1978, Vol 2, page 1742) claims the findings highlight some of the serious problems arising from current patterns of drug addiction.

One of the main values of an index of addicts was to serve as an epidemiological monitor, but this function could not be fulfilled if the index was incomplete. At present, the British index probably provided only an underestimate of opiate use.

"One way in which the index might be modified to reflect more accurately the prevalence of all serious forms of drug addiction would be to extend compulsory notification to include all self-injectors," the authors stress.

They comment that 80% of the addicts in the five-year survey had injection marks although there was some evidence that self injection was becoming less common.

Dr A. Hamid Ghodse, St George's Hospital, London SW17 0QT, and M. Sheehan, B. Stevens, C. Taylor, and G. Edwards, Addiction Research Unit, Institute of Psychiatry, London SE5.

NB students—45% drink to get drunk

By John Carroll

FREDERICTON — Analysis of a study done in mid-1977 reveals one-quarter of high school students questioned, and 6% of junior high pupils, were frequent drinkers.

The study was financed by the Non Medical Use of Drugs Directorate (now Promotion and Prevention Directorate) and sponsored by the New Brunswick Alcohol and Drug Dependency Commission. The sampling, between May 10 and June 10, 1977, took place in the area between Fredericton and Edmundston. It involved random sampling of 1,500 or 10% of the students in 42 schools within 25 miles of the Trans-Canada Highway.

The questionnaire contained 94 questions, took about 45 minutes to complete, and was answered by 949 English-speaking and 590 French-speaking students.

The major finding was that half of all students polled had used alcohol, while 17% had used marijuana.

The analysis, released in December, 1978, shows 75% of the high school drinkers reported usual consumption of three to five bottles of beer, glasses of wine, or drinks of liquor, at a sitting. Forty percent admitted usual consumption of sufficient amounts to become intoxicated, at least six to eight drinks per sitting.

Thirteen percent of the high school, and 4% of the junior high students drink enough to get intoxicated four or more times a month.

Half of the Grade 12 students, and one-quarter of the Grade 11 reported customarily buying their own alcohol, with one-half of these groups saying that they could do this without false identification or lying about their age.

Visits to taverns and bars between five and 10 times in the previous six months were reported by one-third of the Grade 12 youngsters and one-fifth of the Grade 11. Twenty percent of the Grade 12 students had been in such establishments at least 10 times in the preceding six months.

Half of those surveyed who held driving permits drove under the influence of alcohol at least once a month, with half of these drinking and driving at least two or three times monthly.

Those surveyed revealed that the single largest cause of trouble with police was alcohol-related.

Campaign pays off

VANCOUVER — Christmas roadblocks netted record low numbers of drivers here this year, and police officials credit a government anti-drinking advertising campaign.

Roadblocks and drinking driving patrols, which were out the same number of shifts as the last two years, stopped 13,494 drivers, compared to an average of about 30,000 the other years.

Brotherhood takes on 'druggism'

Teamsters vs. alcoholism

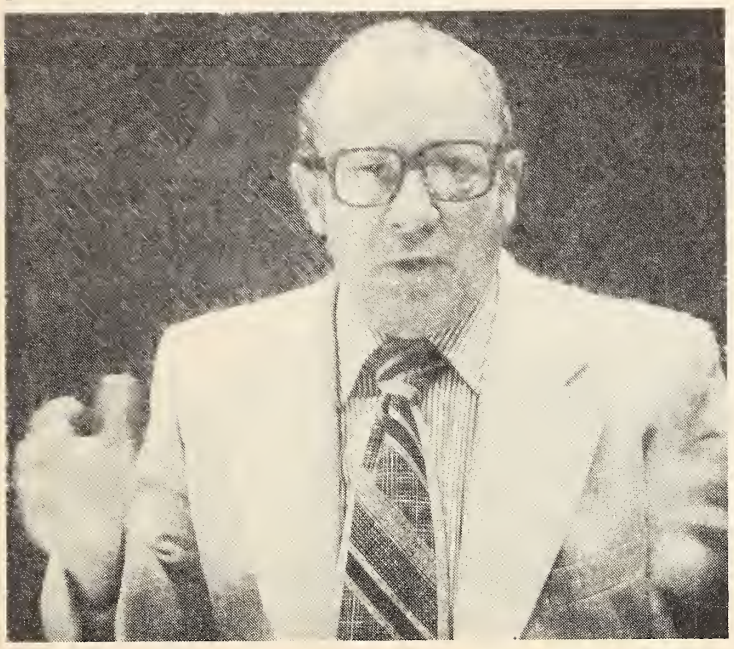
By John Braddock

VANCOUVER — It started with Canadian Teamster boss Senator Ed Lawson and has now been accepted by the powerful union as a nationwide policy — a comprehensive information and counselling service on alcoholism among the Brotherhood.

The man recently hired to lead the drive is A. A. W. "Duke" Parrish, the newly appointed director of the Canadian Conference of Teamsters' human relations department.

For the past 15 years, he's worked for the Alberta government, first with the attorney-general's department as a counsellor within jails and as a supervisor of half-way houses, and later as consultant with the Alberta Alcohol and Drug Abuse Commission's community extension services as counsellor in the educational system.

Mr Parrish says his headquarters will be at the conference offices in Vancouver, and he intends to get to know the various alcoholism counselling and treatment agencies in the West first. "But I will be going across Canada."



A. A. W. "Duke" Parrish: Climate on alcoholism changing in Canada.

He told **The Journal** Teamster efforts to combat alcoholism will be keyed in with such employee counselling services as Interlock in British Columbia, the various provincial alcohol and drug abuse commissions, and organizations for management and business agents.

"It's very much a joint effort. We can't succeed otherwise," he commented.

Mr Parrish believes the climate on alcoholism is changing in Canada, in that people are beginning to speak more openly about it, and it's being treated more like a disease. But there's still a long way to go.

"Canadians are the most defensive minded people on the face of this earth when it comes to talking about drinking. They will talk about cancer, they will talk about TB in the work place, and deep-seated emotional problems, but they will not talk about alcohol," Mr Parrish said.

And: "They have a world-wide reputation as people who drink to get drunk. This is a Canadian. He comes by it honestly. It's all been thrown up to us over the decades — this misinformation and mythologies about the legally pushed drug, alcohol. Canadians do not have a drinking culture to which they can refer. What is sane behavior when you drink?

"Many people say they are not addicted. Well, if they are not addicted they must have a very strong dependency, because I don't know how many people I've talked to — average Canadians — and they would not view themselves as alcoholics and neither would I. But, if you look at their dependency they cannot converse, they cannot have a relationship possibly involving sex, and anything like that, unless they do have something to drink."

Mr Parrish said he's "not hysterical about alcoholism; I don't see an alcoholic under every rock" but he considers it "an insiduous disease" in that nobody decides after the first drink they're going to become an alcoholic.

"Druggism, including alcoholism," said Mr Parrish, "is symptomatic of feeling, coping, and living problems."

He said he sees his role mainly as an informational one, talking to business people and the general public, as well as Teamster members, to encourage frank discussion, to help to remove the stigma associated with alcoholism, and to ensure help is accessible to the Brotherhood of Teamsters membership.

Mr Parrish is a blunt and colorful speaker:

"I think it's anybody's God-given right to become an alcoholic if they're disposed that way. It's also their God-given right to get some help, too."

Clergy vs. alcoholism

MINNEAPOLIS — Alcoholism is an embarrassment to the clergy because it reminds them of failure, according to the Reverend Philip Hansen, executive director, Foundation for Living, Abbott Northwestern Hospital, Minnesota.

Preachers and priests "hit alcoholics over the head with the New Testament" and all they get is a converted drunk on their hands, he said at the Third National Conference on The Impaired Physician.

The clergy is just as helpless as doctors when it comes to reforming alcoholics, Mr Hansen maintains.

He feels churches of all denominations have been as much the problem as the solution.

The church has too often not known enough about alcoholism and chemical dependencies to know what to look for, he said.

Doctors, clergymen, lawyers, managers or anyone else who works with people, who don't have at least a thumbnail understanding of alcoholism and chemical dependency, aren't really as competent as they should be, he said.

At the root of the problem, Mr Hansen believes, is the lack of understanding of others.

Preachers and priests are often unable to help because they don't know how.

"Just because I adhere to a theology and am well versed in its mental gymnastics is no guarantee I know anything about living."

The same is true of physicians or behavioral scientists.

"I have often said they taught me all about God at the seminary and very little about people.

"I haven't run into God once since leaving the seminary, but I keep encountering people all the time.

"Perhaps we need to learn a bit more about how to live, and weave it into each of our disciplines."

Teens on jimson weed see 'sharks on dry land'

By Jean McCann

EL PASO, TX — A combative, swearing teenager with a red face, rapid heart rate, dry mouth, and fever, and who sees such sights as sharks following him on dry land, is likely to be the victim of one of the latest rages among adolescents — jimson weed intoxication.

M. Schydlower, William Beaumont Army Medical Center here, believes such teenagers require immediate stomach-pumping and admission to intensive care.

In what is the largest reported series so far of such severely intoxicated teenagers treated in hospital — 29 over a three-year period — Dr Schydlower also reached some conclusions about treatment.

The first step, he said, is to pump the stomach, using a large-bore tube, to get rid of any seeds or seed pods remaining there. This can be done as late as 24 to 48 hours after the ingestion, since atropine in the weed causes a slowing of absorption.

Intravenous fluids will also help excrete the poison, he said. Sedatives are rarely needed, and phenothiazines are contra-indicated because they would add to the effects of the atropine.

It may also be necessary to catheterize some, because they have urinary retention.

Dr Schydlower characterized the patients as "hot as a hare, blind as a bat, dry as a bone, red as a beet, and mad as a wet hen," and said symptoms are identical to those seen in atropine-scopolamine poisoning. If the test gas liquid chromatography is available, atropine will show up in the urine and thus be diagnostic.

The atropine in the jimson weed is rapidly absorbed from the gastrointestinal tract, he said, and distributed to tissues throughout the body, including the central nervous system. However, from 15% to 50% of it is excreted in the urine.

Dr Schydlower said every part of the plant contains the developmental alkaloids atropine and scopolamine — including the seeds, leaves, roots, flowers, and stems. However, most patients had taken the seeds, which are enclosed in a spiked pod containing from 50 to 100 brown-black seeds. Generally, no more than 100 seeds were ingested.

Every 10 seeds equal about 1 mg of atropine, he said. With ingestion of only one-half mg, "basically what you get is dryness of the mouth. At 2 mg, you get a rapid heart rate and dilated pupils; at 5 mg, dry skin and some urinary retention; at 10 mg, you get the hallucinations and delirium. Most of our patients took that much."

Dr Schydlower said doctors should be aware of this trend in drug abuse.

Although all of his patients recovered uneventfully, some deaths have been reported. One was an adolescent who wandered out in the desert and died of exposure. Another drowned in a swimming pool "looking for red-eye dolphins."

The combativeness of the victims also makes for a potential for violent harm to themselves or to others. He suggested "judicious use of padded restraints" in hospital, when necessary.

Jimson weed is a contraction of "Jamestown weed," a term coined in the 1600s by a group of Jamestown, Va settlers who made the mistake of using the weed in a salad. Other names for it today include devil's weed or devil's apple, stinkweed, thornapple, and loco weed. The botanical name of the plant, which grows all over North America, is *datura stramonium*.

Tobacco and birth defects

ERLANGEN — Five cigarettes daily during pregnancy are enough to cause permanent injuries and deformities in newborn infants, according to a researcher here.

Defects, according to Matthias Wenderlein, Erlangen University's Obstetrical Clinic, include respiratory ailments, cleft palates, low resistance to infection, growth retardation, and premature and still births.

Expectant mothers know too little about these dangers, according to Dr Wenderlein. He advocates more educational work and, as a starter, has recently completed a pilot study among 500 women examining their smoking habits.

Cigarette smoking, he concluded, is most prevalent in the female age group with the highest pregnancy proclivity — those women under 30, of whom 40% smoke an average of 10 cigarettes or more daily.

Now from the APA: Tobacco Use Disorder

By Dorothy Trainor

MONTREAL — For the first time ever, smokers have found their way into the soon to be published DSM-111 of the American Psychiatric Association (APA).

DSM-111? It's the third edition of the *Diagnostic and Statistical Manual*, the APA's classification of mental disorders. Under Substance Use Disorders, one now finds Tobacco Use Disorder.

DSM-111 is not yet official, however, and won't be until about mid-1979 when publication will occur. In the meantime, changes may be made in definitions.

The inclusion of Tobacco Use Disorder doesn't imply all smokers are mentally disturbed. They will find their condition in the pages of DSM-111 only if additional criteria are met.

"Using the criteria presented here, a heavy smoker who has no serious tobacco-caused or tobacco-aggravated physical problems and who denies concern about smoking, does not have Tobacco Use Disorder. Should the same individual exhibit concern about an inability to stop smoking, the behavior would meet the criteria for such a disorder," the manual states.

Although the section on Tobacco Use Disorder is lengthy, the message, in summary, is this: "In this manual, the use of tobacco is considered a mental disorder either when the use of the substance is directly associated with distress at the need to use the substance repeatedly; or there is evidence of a serious tobacco-related physical disorder in an individual who is judged to be currently physiologically dependent upon tobacco."

***Psychiatric News* (the newspaper of the American Psychiatric Association) in a story on habitual smokers states: "The inclusion (in DSM-111) of smoking behavior is better understood when one realizes that some patterns of tobacco use meet every criteria for compulsive drug use, even if it has been difficult to develop satisfactory animal models of nicotine physical dependence."**

MDs workaholics, then alcoholics

By Dorothy Trainor

MONTREAL — Overworked doctors turn to alcohol or drugs to alleviate their insecurities and anxieties all too often, Merville O. Vincent told the Second International Seminar on Terminal Care here.

Dr Vincent is the psychiatrist/director, Homewood Sanitarium, Guelph, Ont, which is one of the few places in North America where the drug-addicted or alcoholic professional can "disappear" for a while.

"Since I have been at Homewood, we have treated over 200 physicians as in-patients. There has been a rather common pattern of morbidity: the physician is overworked, narrowly preoccupied with the practice of medicine often 20 hours a day, never says NO to any additional patients, speaking engagements, etc, and stays on the treadmill at all times.

"These rather compulsive and perfectionistic people begin to get tired, discouraged, cynical over the amount of work, and find that they just can't stay organized. Being compulsive, it is difficult for them to find themselves disorganized.

"At this point, it is so easy for them to begin treating themselves with drugs or alcohol, or using minor tranquillizers and moving on from sedation to narcotics. It is not surprising that there are a lot of marriage breakdowns and even suicides," he said.

"Physicians are the only people I know who brag about never taking a vacation. Everyone else I know is on strike to demand at least another week. The physician has to realize that problems are infinite but energy is finite."

The first pitfall in medicine, he said, lies in role-strain.

"By role-strain I do not mean that we do not know what our role is, but rather that we do not know how to live with it. In a cartoon, Charlie Brown said: 'I have an identity crisis.' Lucy said: 'You mean you don't know who you are.' Charlie said: 'No, I know who I am. That's the crisis.' So it often is in medicine. But it is all the more a crisis if we define our role in the wrong way — in a way that produces extraordinary stress," Dr Vincent observed.

"When I went to medical school, my role was not specifically stated but I got the message that it was to stamp out suffering, disease, and death. Later I found out that no matter what I did, I was surrounded by disease and death; that patients who got well didn't come back, and the ones who came back were still suffering. And I knew that all my patients were going to die ultimately. So it became a difficult role to live with."

The consequences are often feelings of despair and guilt. What happens then, Dr Vincent said, is that doctors try to run faster — to see more patients in order to have more successes.

Fatigue and overwork affect them, and they try to treat their discomfort and move into difficulty with alcohol or drugs and possibly depression and even suicide. On the other hand, the defence may be different and, about middle-age, they develop a cynicism about medicine.

"I suggest that the doctor's role can be more constructively looked at and more easily lived with if we see our role as simply helping to bear suffering, disease, and death," he said. "A role we can live with is 'to cure sometimes, to relieve often, and to comfort always'."

Dr David Smith: Key problem addicted doctors face is overcoming the denial.

Drug-addicted doctors have better chances for cure

By David Milne

MINNEAPOLIS — Doctors who become drug addicts or alcoholics stand a better chance of rehabilitation than the average street addict, according to David E. Smith, director of the Haight-Ashbury Free Medical Clinic, San Francisco.

The key problem addicted doctors face is to overcome denial and to admit they need help, Dr Smith told the Third National Conference on the Impaired Physician.

Once they do this, chances of recovery are good, provided the treatment plan is designed especially to individual needs.

Doctors generally identify strongly with their profession, which serves as a prop for their egos while they undergo treatment, said Dr Smith.

If they can keep their practice intact while undergoing treatment, they have few problems in returning to work, he said.

Addicted doctors have certain common characteristics which help determine their treatment and management:

- They are generally loners, they don't congregate with other substance abusing doctors, and they limit their contacts with others for fear of being discovered.
- They go to great lengths to deny their problem and to maintain the illusion that their lives are under control.

Taking the initial history and making treatment plans for detoxification is complicated by two factors: an unusually high level of physical dependence and the physician's attempt to minimize the severity of the problem, Dr Smith said.

Because doctors have access to pure drugs and large doses, their level of dependence is often unusally high.

Medical management, although an essential service in the treatment of street addicts, is of secondary importance in the treatment of addicted physicians because they are better able to care for their bodies.

Dr Smith said the physician abuser tends to overdose less than the street junkie, "because they are abusing relatively pure drugs at relatively set dosages, and their training in medicine and pharmacology allows them to stay clear of the accidental overdose."

Because they have this knowledge, and because of their strong desire for anonymity, physician abusers are less likely to show up in emergency rooms as overdose victims.

The glue sniffer is missed by conventional treatment

WINNIPEG — Glue sniffing can start in children as young as 2½ years old although the average starting age in inner city children is six or seven years, a study has revealed.

This means youngsters are moving in a circle where "a 10-year-old is king," says Sister Geraldine McNamara, director of Rossbrook House, an agency for young people.

What's needed to combat the problem is not more government social workers but action at the neighborhood level, she told a Winnipeg city council committee on youth needs.

She called conventional efforts to stop glue sniffing wasteful, expensive, and complicated, and said "only the social workers benefit."

Such government programs "don't help the community, and leave nothing behind" when funding stops, she said. "When two six-year-olds spend an entire weekend in the attic, they don't need a battery of social workers, they need an alternative."

In her attack on what she called wasteful programs, Sister MacNamara cited as "contemptible" government efforts to have a paid case worker replace Rossbrook House volunteer workers who live in the community and know all the youngsters exposed to glue sniffing and other harmful activities.

"The minute a kid hits the jackpot (gets picked up by police) he is given a per diem rate and sent through the system. This drives the kid crazy," Sister MacNamara said.

"He doesn't need minimum security — all he needs is a bed."

When a youngster high from glue sniffing makes his way to Rossbrook, one solution is "a simple drive along the perimeter highway with the windows down," she said. "It clears the passages."

She said the city should tabulate, and make public, the number of times police are used to pick up children "as young as three-years-old" to transport them to the Manitoba Youth (detention) Centre."

Such statistics would show taxpayers "how prohibitively costly and wasteful" such methods are. Instead, the provincial child welfare director should be responsible for the services under the Child Welfare Act, Sister MacNamara said.

She suggested establishing centres for young people aged 12 to 19 in some of the worst areas for glue sniffing and other harmful or unlawful activities.

Using available buildings, the shelters would open on a 24-hour basis, be staffed by local community helpers, offer sleeping accommodation "for those seeking refuge from unsafe or unsavory home situations" and good food which can be prepared by the children themselves.

Sister Geraldine: Attack on 'wasteful' programs.

Cut-rate drugs dispute

WASHINGTON — Major drug manufacturers in the United States have filed suit to stop the government from encouraging doctors and pharmacies to fill prescriptions with cheaper, generic equivalents of brand-name drugs.

The Pharmaceutical Manufacturers Association, in a suit filed in US District Court in Baltimore, charges that publication of a guide to wholesale drug prices, and a list of supposedly equivalent drugs, would mislead the public, physicians, and pharmacists.

The price list was due to be published in January by the department of health, education, and welfare, and a separate list of "therapeutically equivalent" drugs is being compiled by the Food and Drug Administration.

The drug manufacturers claim publication of the new price lists would cost them money, as doctors would be encouraged by official government lists to write prescriptions for cheaper, imitative drugs.

Identity crisis warning

TOLEDO, OH — It is pure fiction to believe that drug-treatment services will be more cost-effective if placed under administrative control of community mental health centres," says director of Toledo Methadone Clinic Jacqueline Martin.

"Drug programs lose their identity and acceptance when they are brought under the aegis of mental health centres," she said in reply to an accounting firm's study on ways to make such community services more economical.

"Many drug abusers simply wouldn't go to mental hospitals because they don't envision themselves as the same kind of people who go there. Drug abusers think crazy people go to mental hospitals. They aren't. They have a drug problem."

She said such a move would rob drug programs of their effectiveness, and damage their credibility.

Pot related to women's infertility?

By Jean McCann

ST LOUIS — The possibility that marijuana smoking is related to infertility in women was raised here by Rhea L. Dornbush, Reproductive Biology Research Foundation (Masters and Johnson organization).

Dr Dornbush told the Society for Neuroscience she found defective hormonal cycles in women who smoked marijuana at least three times a week, as against those who didn't smoke it at all.

"Although chronic, frequent marijuana use *per se* could not be implicated as a cause of anovulation," the evidence in this study of 42 smokers and non smokers, aged 18 to 30, was suggestive, she said.

"Defective menstrual cycles — those that were either anovulatory or marked by an inadequate luteal phase — occurred 38.3% of the time in the marijuana-using women, compared to a rate of only 12.5% of the cycles of non marijuana-using women.

"Since problems of the luteal phase have recently been increasingly recognized as a significant cause of infertility, the implications of this finding may be of considerable practical importance."

The luteal phase is that part of the menstrual cycle following ovulation and is the only time when it is possible for a fertilized egg to be implanted in the uterine wall. Although the luteal phase is ordinarily about 14 days in length, in the marijuana smokers it was often 11 days or less.

Another finding in the study — believed to be the first on the endocrine effects of chronic marijuana use in women — showed women who smoked had higher average levels of testosterone in their blood throughout the menstrual cycle. This contrasts with previous data showing that smoking marijuana *decreased* blood testosterone levels in young men.

Dr Dornbush said the difference is most likely attributable to the fact this so-called "male" hormone, which is normally present in much lower levels in women, is synthesized at a different site in the body in each sex.

"Although almost all circulating testosterone derives from the gonads in men," she said, "in normal women, as in prepubertal children, a large fraction of testosterone production is of adrenocortical origin. Since marijuana is known to stimulate the pituitary-adrenal axis (the connection between the pituitary gland in the brain and the adrenal gland near the kidney) it is most likely that this explains the apparent inconsistency."

She was unable to postulate why the blood prolactin levels in the smoking women were significantly higher, statistically, than in the non marijuana users. (Prolactin is another brain hormone, associated with human lactation.)

Dr Dornbush said the women, being of child-bearing age, could not ethically be given graded doses of marijuana in the laboratory. They smoked on a casual basis and then reported to the researchers.

There was also greater alcohol use by the marijuana smokers than the non smokers, she said.

"The possible influence of alcohol as an independent variable on menstrual cycle length, anovulation, or hormonal data, is unknown, as are the possible synergistic, additive, or antagonistic effects of alcohol and marijuana use."

Dr Dornbush said despite this, "the results of this study are reasonably consistent with the data available from animal experimentation."

Marijuana damages brain : Doorenbos

By David Milne

SALT LAKE CITY — Marijuana probably causes brain damage, says a researcher who claims it is the most dangerous street drug in America.

In light of what is known about marijuana's toxicity, it is irrational to say it is a safe alternative to any other drugs, says Norman Doorenbos.

Marijuana may not be addicitve but it should not be considered a safe alternative to other drugs such as alcohol or tobacco, Dr Doorenbos, dean of the College of Science, Southern Illinois University, Carbondale, told the American Chemical Society meeting.

Dr Doorenbos has done extensive biochemical and botanical studies of the marijuana plant, particularly at the University of Mississippi where, in 1968, he began The Marijuana Project, growing plants for National Institute of Health approved research.

"Many researchers believe marijuana can cause brain damage, and it is my feeling it does.

"It has two known effects on the brain: first and most immediate is that it affects the thought process.

"Someone who is really high on marijuana is not, for example, a safe driver. His perceptions are distorted. His ability to decide is impaired.

"It is characteristic of marijuana smokers to begin a sentence, then not be able to end it because they forget what they are talking about."

One long term effect marijuana smokers have noticed is a dulling of the intellect so they cannot perform mental tasks as well as they did before, he said.

The marijuana plant contains many drugs, only a few of which affect the mind. Others affect the body. There are at least 40 cannabinoids, plus other elements such as alkaloids, which can have a strong toxic effect on humans, he said.

Polish leaders enlist Church in attack on alcohol

MUNICH — With the world's highest per capita hard liquor consumption and a mounting alcohol abuse problem (**The Journal**, Nov. 1978) Poland's Communist regime is now turning to the country's powerful and influential Catholic Church to help combat the nation's greatest social ill.

The pandemic spread of alcohol abuse in postwar Poland has been a constant cause of concern for Church leaders.

Pastoral letters and exhortations have described it as threatening the nation's biological and moral substance, and have called on the authorities to adopt tougher measures to combat it.

But the Church has only limited means to carry out any effective action in this area because it is denied the right to any form of organized social work.

Now there are signs, in the wake of improving relations between Church and State, that this might change. The government, it appears, is seeking Church assistance in the struggle against social evils.

In a recent interview, Kazimiers Kakol, the head of the government's cabinet-level Office for Religious Denominations, said that the state expects the Church to join the fight against alcoholism.

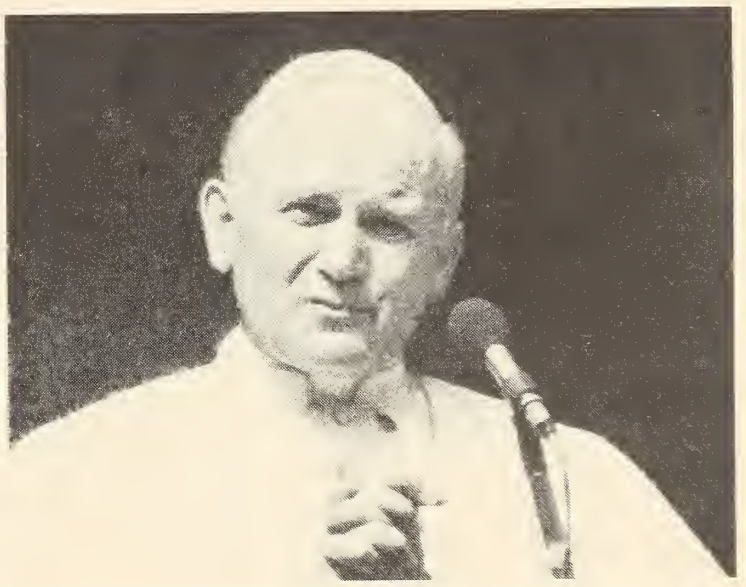
The Church has been authorized to set up "anti-alcoholic" circles in numerous parishes in recent months.

A bishop, Msgr Jan Mazur, head of the episcopate's commission on alcoholism, has been invited to discuss publicly the Church's methods for combatting alcoholism in the semi-official and official media.

He called for forming a "united front" in the struggle.

While the Church can use religious and moral arguments, lay and quasi-governmental organizations such as the Social Anti-Alcohol Committees should rely on humanistic and economic reasons to cut down consumption.

Both sides, he stressed, are working toward a common goal.



Poland, Pope John Paul II's native home, and one of the most devout Catholic countries in the world, is trying a new approach against alcohol abuse.

West Germany facing sharp drug abuse increase

MUNICH — A sharp increase in hard drug use and trafficking was recorded by West German authorities in 1978.

During the first half of 1978, according to the federal ministry of interior, police throughout the country confiscated 120 kilograms of heroin — almost double the amount in all of 1977.

In Bavaria, according to the state interior ministry, the number of known hard drug users has increased by 14%.

Deaths from over-doses in the state increased from 50 in 1976, to 57 in 1977, and to 30 during the first six months of 1978.

Half of the deaths recorded during the first half of 1978 were addicts between 22 and 24 years of age; 18 were women.

On the other hand, according to Bavarian authorities, there has been a decline in drug abuse and hard drug use among teenagers with addiction becoming more prevalent in older age groups.

There has also been a pronounced increase of heroin and other hard drug use in rural areas formerly considered relatively safe and immune. In Franconia, a region of Northern Bavaria that is predominantly non-urban, the increase has been 39%.

West Germans' drinking is at all time peak

MUNICH — Alcohol consumption in West Germany is at an all-time peak, according to recently released government and industry statistics.

In 1977 — statistics for 1978 will not be available until late this year — per capita consumption of spirits was 6.8 litres, wine 23.4 litres, and beer 148.7 litres. This represents a 300% increase in per capita consumption over 1950.

The total amount spent for alcoholic beverages by West Germans in 1977 was DM 29.1 billion (approx. United States $15.3 billion) equal to DM 550 (about $289) per capita.

Every second D-mark spent for beverages is spent for alcoholic ones.

The West German government also reaps a handsome profit from its citizens' alcohol consumption — more than DM 5 billion ($2.6 billion) in taxes.

Pain-killer dosages level off for dying

MONTREAL — Use of pain-killing narcotic drugs for the dying patient does not lead to sharply increased dosages but levels off at surprisingly moderate plateaus, according to Cicely Saunders, founder of England's first hospice.

"Tolerance is not a clinical problem. Everybody is afraid increased tolerance is going to be a problem, and it's not," she told the Second International Seminar on Terminal Care here.

Dr Saunders, a pioneer in the hospice movement, which focuses on the care of the dying, started St Christopher's in London, and is its medical director. The movement is now capturing interest around the world.

Dr Saunders, said that previously St Christopher's had been using heroin either by injection or by mouth, but they have now changed to morphine by mouth, keeping heroin to be used by injection because of its solubility.

"The dosage goes up quite stecply for six weeks, is less for 12 weeks, and then very much less up to the 24th week."

Dr Saunders said that in the last five years, only 34 patients had unresolved pain problems, "which is 1% of the 3,360 patients in whom we have had to deal with pain problems.

"Anticipation is very much a part of our pattern of pain control. We must anticipate the pain reaction so that the patient does not have to," Dr Saunders said.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Hold that applause on drug reforms

Comment
By Jeff Carruthers

OTTAWA — Many Canadians, including those tens of thousands with criminal records from cannabis possession crimes, have been waiting a long time for the cannabis reform promised by the Liberal government in Ottawa some seven years ago.

Now, it seems the Liberals are planning to try again.

However, more than ever before, there are questions demanding to be asked and answered before the public applauds this latest move.

The first is why now.

The second, is why in this fashion.

On the surface, the explanation for this revived interest seems clear enough. More than 33,000 Canadians, most of them young, are being hauled into court each year on cannabis possession charges. The courts are clogged. The judges and the lawyers and the clients are all unhappy.

More and more Canadians are stuck with criminal records, many of them without realizing it, even as recent surveys reveal that more Canadians have tested and tasted the sweet-smelling weed; and more now believe the existing laws, which equate cannabis with narcotics like heroin, are too tough.

Both Prime Minister Pierre Trudeau and Opposition Leader Joe Clark have publicly stated it is time for this situation to change, though they add that there are other, more urgent matters to resolve. (Their positions emerged during the last pre-election scare, and have since been repeated.)

But all of that doesn't explain the sudden "urgent" study of cannabis reform within the justice department. Even more inexplicable is the rush to review something the government admits will likely never have time enough to be passed by parliament before the election. And after that, who knows?

Supporting actress

At this point, it would be easy enough to be cynical and conclude that the Liberals (and the Conservatives) are just out to get votes. And what's new about that?

Yet, other clues suggest quite different motives.

It is the Justice Minister who is taking the initiative, not Health Minister Monique Begin. While Ms Begin seems definitely in favor (her heart is in the right place), she is a supporting actress at best. And the principal, Mr Lalonde, is showing considerably more interest now as Justice Minister than he did as Health Minister, when he failed to get a Senate cannabis bill passed by the Commons.

Also interesting is the fact Fisheries Minister Romeo Leblanc, a close confident of both Mr Lalonde and the prime minister, has been making public statements about the problem of giving young Canadians criminal records for simple possession. He has been suggesting there might be ways around the problem, either by eliminating the records quickly or not issuing them in the first place.

But, what has a fisheries minister got to do with a health matter? Unless, it is no longer being perceived as a health matter; and unless Mr Leblanc is acting as a stalking horse for Marc Lalonde in Justice.

It is also noteworthy that the bureaucrats talk about toughening up drug laws in other areas. For example, possession of amphetamines or speed is likely to be made a crime, even as simple possession of cannabis is being decriminalized.

All the signs point to an inescapable conclusion: this is not cannabis reform or even drug reform. It is law reform and possibly much more.

Justice Minister Lalonde says publicly that public attitudes have changed, yes. Now perhaps is a better time, for a politician, at least like Mr Lalonde, who as health minister couldn't finish what he is trying once again to accomplish.

But it is also Mr Lalonde the justice minister who expresses (in a more tell-tale fashion) his government's concern about disrespect for the law. It is not that more Canadians are getting thrown in jail for cannabis crimes so much as it the fact so many more are not getting caught and are getting away with it. The law is being flaunted openly at all levels of society, lawyers included, and in all corners of this land, all the way up Sussex Drive to Rockliffe Park and beyond.

Tightening powers

Little is said in public about plans to tighten up on the broad powers of search and seizure given many drug squad members, who may now enter any place in which they merely suspect illicit drugs might be found. Yet that too is in the works. And, almost in passing, Health Minister Begin says she wants "policing" powers in the drug field transferred out of her department, elsewhere.

The trail signs point to the justice department as the ministry to which ultimate discretion in all areas of drugs is being funnelled and where both policing powers and judicial jurisdiction, and penalties, will be coordinated in the drug field for the first time.

Implications

The implications of all this remain unclear as does the answer to the question: why the government decision to act, and especially why now? Certainly not public opinion or election fever — election strategists usually don't like to confront "hot" issues. Certainly not concern about civil rights, not unless the Liberals have suddenly taken on new garments. Perhaps concern about efficiency — how best to crack down on drug use without undercutting too much Canadians' respect for the law.

But one thing already seems clear: it's being done backwards, simple and straight. The lawyers and the policemen are saying the law isn't working, so let's all fiddle. Forgotten are the policy objectives behind the law. What is society trying to do with drug laws, for one?

At this point, someone has to ask whether drug abuse, which slowly became accepted as a health problem where action was taken to protect individuals from themselves as much as society from individuals, is now to be regarded as a crime against the state, period.

Perhaps the issue in the upcoming election should not be "when cannabis decriminalization" but "why now" and "to what end?"

Editor... Letters to the Editor... Letters to the Editor...

Alcohol use will *increase* in 1979

The new feature by Richard Gilbert is a welcome addition to **The Journal**. However, in his inaugural column in the January issue, Dr Gilbert rather brazenly predicts per capita alcohol consumption in Ontario will decrease in 1979. Unfortunately, that is highly unlikely: a more thorough review of the evidence leads to the exact opposite conclusion — alcohol consumption in Ontario will increase in 1979.

Dr Gilbert claims money will be scarce, with wage increases more than offset by price increases. It would be more accurate to describe the situation as one in which disposable income has been relatively constant. That is, wages and prices are increasing at approximately the same rate. Because it is relatively constant, disposable income will have little bearing on the trend regarding alcohol consumption.

Dr Gilbert predicts alcohol prices will go up, more than in recent years. Even if it were true that prices will be increased more than in the past, it is highly unlikely they will be raised in real dollar terms. The record over the past two decades, when the provincial government was similarly "strapped for money," indicates the government is likely to permit the real price of alcohol to continue to decline.

The third reason given for expecting a decline in alcohol consumption is the introduction of light beers and the substitution of table wine for sherry.

First of all, there is no evidence the introduction of light beers will lead to a decline in the consumption of higher alcohol content beers. Instead of becoming a substitute for the less desirable beverages, the new beverages tend to be consumed *in addition*, and thus only serve to increase total alcohol consumption. Would the breweries have pushed for the new light beers if they did not expect to create new markets and thereby increase sales?

Secondly, the decline in the consumption of sherries is largely attributable to a differential pricing policy which the LCBO began in 1969 when it increased the price of domestic sherry to correspond more closely to the mean price per unit of alcohol. Until then, sherry was the preferred beverage of skid row alcoholics. The LCBO disproportionately increased the price of domestic sherry and hence, its consumption declined. The consumption of table wine had been increasing well before the consumption of sherry declined.

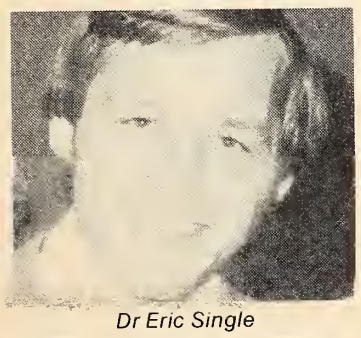
The fourth reason Dr Gilbert offers is that fewer people will be allowed to buy alcohol. It is true 18-year-olds will be excluded from the drinking population, but
1) they currently consume about 1% of total consumption;
2) they will likely continue to consume alcohol but a lower rate;
3) their losses will be more than offset by other groups of new drinkers entering the scene: women, immigrants, former abstainers, etc.

As for Dr Gilbert's fifth reason, the closing of liquor stores, one wonders how he is so certain store clerks will strike.

Finally, Dr Gilbert has ignored some evidence which indicates an increase in alcohol consumption. As the progeny of the post-World War II "baby boom" are now reaching peak drinking age (between 25 and 35 years of age), it can be expected that consumption will increase. Another cause for concern is the continuous trend toward greater availability. These factors, coupled with the expectation that the real price of alcohol is likely to continue to decline, lead me to the expectation that per capita alcohol consumption in Ontario will not decline but increase in 1979.

Dr Eric Single, Scientist
Social Studies Department
Addiction Research Foundation
Toronto

Dr Single is the senior author of a recent analysis of trends in consumption, entitled Rates of Alcohol Consumption and Patterns of Drinking in Ontario 1950-1975 *(ARF Substudy No. 961).*



Dr Eric Single

Cartoon stereotypes

I welcome **The Journal** as a significant component of my reading, and respect the quality of its construction.

I take exception, though, to the editorial cartoon appearing in the December, 1978, edition, and for all the typical reasons:

- it stereotypes nurses as females, and sexy little ones at that;
- it stereotypes pot users as members of a sub-culture;
- it expresses the obvious.

None of these criticisms should be taken too harshly, and I can appreciate your wish to introduce levity to counterbalance the fundamentally serious tone of your publication.

At the same time, I think you may find continuing difficulties in striking just the right balance.

Ronald Marks,
Toronto

Printers' apology

The printers of **The Journal** have apologized for their mistake in the January issue on pages 8 and 9, and have agreed to compensate disappointed readers. The centre spread poster, with the United Nations Declaration of the Rights of the Child, should have had white lettering on a black background rather than the less easily read white letters on a pale grey background. Readers who would like copies of the poster, as it was intended to appear, are invited to write for copies to **The Journal**, 33 Russell Street, Toronto M4Y 1R7, Canada.

GILBERT

'Second-hand tobacco smoke is unpleasant and unpopular but not necessarily unhealthy.'

By Richard Gilbert

Snuffing the myths of second-hand smoke

Few things I have written have been as controversial as the following sentence, included in the July 1976 version of the Addiction Research Foundation of Ontario's Facts about Tobacco:

"There is no evidence that a tobacco smoke-filled environment is bad for the health of healthy non-smokers, except possibly children."

Much of my time in 1977 seemed to be spent justifying this assertion to angry callers and correspondents. As late as September 1978 there was a letter in **The Journal** describing the offending sentence as a **non-fact** of the kind to be expected from the "cloudy thinking" that might occur in a tobacco smoke-filled environment. By then I had revised Facts about Tobacco. Under pressure from the ARF's Information Division, the sentence appeared this way in the January 1978 version:

"There is only indirect evidence that a tobacco smoke-filled environment is bad for the health of healthy non-smokers."

The facts had hardly changed, but the militant anti-smokers seemed to be mollified.

Now the facts have changed. The year 1978 saw the publication of some important studies on the effects of second-hand cigarette smoke. The most extensive was conducted in Toronto. The authors concluded that the acute effects of passive inhalation of large amounts of tobacco smoke are "small and of questionable biological significance." A Danish study concluded that "a lasting, adverse health effect in otherwise healthy grown-up individuals seems improbable."

None of these studies examined the effects of *chronic* exposure to second-hand smoke on health, which remain largely unknown. Direct epidemiological evidence of health risks of long term exposure to tobacco smoke exists only for young children. They are more likely to experience respiratory infection if their parents smoke. There is also good evidence that passive smoking aggravates certain heart disorders in adults. In summary, there is direct evidence that the health of a minority can be prejudiced by second-hand smoke, but none that the majority is endangered.

The indirect evidence should not be ignored. Tobacco smoke contains potent carcinogens. Because carcinogens may exert their effect in direct proportion to the level of exposure, even the extremely small amounts inhaled by passive smokers could conceivably be cause for concern, especially if other cancer-causing agents are in the air.

Nevertheless, campaigns against public smoking do not get much support from the data on passive smoking and physical health. They do not need to. The unpleasantness and unpopularity of tobacco smoke are established beyond question.

In the Canadian and Danish studies mentioned above, nearly all subjects complained of eye irritation when they were exposed to cigarette smoke. Many reported nasal discharge or stuffiness. Tobacco smoke is clearly unpleasant.

Toronto's By-Law 398-77, restricts smoking in 20,000 public places in the city. It has the approval of a large majority of residents, according to a survey conducted when it was passed in the summer of 1977. Compliance with the by-law has been substantial. Enforcement has not posed problems for city officials. Tobacco smoke is clearly unpopular.

A new reason has emerged for restricting smoking. When cigarettes are being smoked, acceptable air quality standards can be met only by changing air six times more often than would otherwise be required. In the totally controlled environments of modern office towers, tobacco smoke puts a substantial load on the ventilation equipment, requiring large and avoidable expenditures of electrical energy.

If smokers cannot be blamed for making you ill, they might at least be blamed for putting you in the dark when the next blackout occurs.

Next Month:
Costing the consequences of drug abuse

You keep us up to date

In the December issue of our project Newsletter *DUI Tieline* we reprinted excerpts of the testimony of Dr Harold Kalant (**The Journal**, Oct, Nov, 1978).

The audience for *Tieline* is a highly specialized one — those who work with alcohol-impaired drivers at the level of the first offence in California. Because of the increasing evidence of marijuana use among drivers, and the combined use of alcohol and marijuana among those arrested for driving under the influence, we thought the Kalant perspective would be particularly relevant.

We thank you for your courtesy in permitting us to use the material. Your publication is a leading resource in the field of addictions, and serves to keep knowledge up to date in many important ways.

Alice Lebel
Project Director
DUI Demonstration Program
University of California
Los Angeles

Relevant to Australia

We find **The Journal** informative and useful for reference.

Unfortunately, the material it contains is essentially for Canadian-American consumption, however it has relevance to us also in Australia.

We congratulate you as editor for the improved presentation, clarity of print, improved quality of paper, and introduction of color, which have all added to the readability.

Bill Athersmith
Secretary
W.A. Temperance Alliance
Perth, Australia

Soviet alcoholics start as teenagers

By John Dornberg

MUNICH — Per capita alcohol consumption in the Soviet Union is rising at a rate of 5% and worried Soviet experts attribute most of the increase to teenage drinking.

Moreover, according to Professor Roman Lirmyan of the USSR's ministry of internal affairs training academy, 90% of the Soviet Union's alcoholics made their first acquaintance with alcoholic beverages before the age of 15 years. A third of them were introduced to alcohol before the age of 10.

Teenage drinking has emerged as a growing problem in the Soviet Union, and in recent months has been given special attention in the official press.

"Alcohol has become 'fashionable' at schools," Prof Lirmyan wrote in a recent article in *Uchitelskaya Gazeta* (The Teachers' Gazette.) "At some schools, 10th graders have even established the tradition of 'washing down' every exam they pass. It is no secret that this trend peaks at graduation time when the *militsia* (police) really have their hands full."

The number of youthful drinkers is not the only cause for concern, according to Prof Lirmyan. "Also disturbing is their cynical bravado and the way in which they taunt and mock their non drinking peers."

He cited sociological studies according to which 49.8% of boys and 31.9% of girls have tried alcoholic beverages at least once before the age of 10.

"More and more juveniles are being sent to us in a state of intoxication," an official at a sobering-up station in the Ural Mountains city of Ufa told a correspondent for *Komsomolskaya Pravda*, the Communist Youth League daily, recently.

The paper contended that teenagers are being encouraged to drink, actively and through example, by adults.

It cited various surveys according to which anywhere from 60% to 80% of juveniles made their acquaintance with alcohol in the presence of, or with the consent of, their parents.

The danger, it maintains, is not so much in children taking part in family celebrations where alcohol is served as it is in the almost unwitting transfer from one generation to the next of drinking habits, and a passion for strong alcohol that leads to addiction.

Although there are laws in each of the USSR's 15 constituent republics under which adults may be severely punished for getting juveniles drunk, according to *Komsomolskaya Pravda*, they are rarely enforced.

The paper cited the case of the city of Kemerovo, population 400,000, a coal mining centre in Siberia. During a six-month period in 1978, not a single adult was charged under Article 210 of the Russian Republic criminal code. Yet during the same period, 46 teenagers were brought to one of the city's several sobering-up stations in a state of total intoxication.

"How many of them had their glasses filled and refilled by adults?" the paper asked. "No one bothered to ask."

Regulations governing the sale of alcoholic beverages to juveniles are constantly violated in the USSR.

The reason, *Komsomolskaya Pravda* admitted with surprising candor, is the system of central planning in the economy and fulfilling artificial sales quotas, according to which store managers' and clerks' bonuses are measured.

"Of course I know the wine department sells to teenagers and that the rules for selling alcohol have been violated," a Moscow grocery store manager told the paper. "And they always will be as long as we work on the 'inventory equivalent' system.

"This means that for every ruble of the plan I should also have a ruble's worth of merchandise. If I don't get 12 bottles of milk delivered to me but one bottle of vodka instead, it's considered that I have the monetary inventory equivalent. And I'm supposed to fulfill the plan. If I do not, the whole store goes without a bonus. As far as the plan is concerned there is no difference between milk and vodka.

"If alcohol were listed as a separate item and my bonus were based on total turnover minus vodka or wine, then I'd observe the rules," he said.

Besides the state's vested interest in producing and selling alcohol, over which it has a monopoly and from which it derives billions of rubles annually in revenue, the approach to the alcohol problem thus far has concentrated largely on the results rather than the causes, taking, for the most part, various forms of punishment for violating regulations.

These include heavy prison sentences, transfers to lower-paid jobs, demotions, withdrawal of bonuses, loss of travel privileges, forfeiture of one's place on the waiting list for apartments, automobiles, and consumer durables, and various other measures that seem to have no success in stopping people from drinking, especially teenagers.

Soviet teenagers' strong passion for drink is learned at knees of celebrating parents, says that country's Communist League daily newspaper. AP photo.

The problem is ignored

Alcohol culprit in W. German work accidents

By John Dornberg

BERLIN — Alcohol is a principal cause of industrial accidents and costs West Germany's employers and insurance agencies some DM 30 billion (United States $15.8 billion) annually.

This was disclosed at the recent congress of the German Addiction Society (*Hauptstelle gegen Suchtgefahren*— DHS) here.

The quota of work accidents due to alcohol consumption is estimated at between 5% and 30%.

There are no reliable figures because no one can be forced to take an alcohol test after a factory or shop accident, although accident prevention regulations specifically prohibit drinking on the job. Fellow workers usually keep quiet and doctors generally make a report of alcohol consumption on accident reports only when it is so obvious that it cannot be overlooked.

On the other hand, there is also a tendency on the part of management to blame drinking when, in fact, faulty machinery or inadequate safety devices were the causes.

Business losses due to absenteeism resulting from alcohol and shoddy workmanship cannot even be gauged. According to some surveys, however, absenteeism among problem drinkers is five times greater than average.

Alcohol consumption is prevalent in all branches of the economy, and blue collar workers are as prone to drink as top-ranking executives.

There is a tendency in West Germany to ignore and cover up the problem of drinking on the job which is considered normal by many people.

The reasons for ignoring the problem are numerous, the congress was told. The social worker of one major company said: "If we were to speak of an alcohol problem in our firm, people would instantly say that it must be due to inhuman working conditions."

Another industrialist reported that shareholders at a recent annual meeting were horrified when the management suggested establishment of an alcoholism treatment centre on company premises.

Company policy on alcohol varies greatly in this country. In about 50% of those in the highly industrialized state of North-rhine-Westphalia, liquor is barred from the premises, but in most of the others it is banned only in "dangerous" departments and work areas.

"It's lunacy to serve liquor in the cafeteria while imposing abstinence in the room next door," West Berlin's senator (minister) for social affairs Olaf Sund said.

Many company managements feel a ban cannot be enforced, in part because liquor is brought to the plant from outside and because labor representatives on the works councils would not support a ban since the members all want to be re-elected.

One participant said bluntly: "Up in the executive suites the effects of alcohol are viewed with concern, but down on the shop floor the drink-vending machines all do a brisk business."

The consensus among delegates was that the problem of alcohol consumption at work could be alleviated somewhat by cutting down on the numerous office parties marking birthdays and celebrating various anniversaries and providing non-alcoholic beverages free of charge for certain types of work.

It would also help to show more consideration for fellow workers who would like to turn down a drink but are afraid of ridicule from their peers.

NFB: Drugs and jobs

MONTREAL — The relationship between unemployment and drug use is one aspect explored in a Canadian National Film Board (NFB) production entitled *Unemployment* soon to be released.

Written and directed by Pierre Lasry and produced by Mark Zannis, the film examines effects of social change on people in trouble because of unemployment — the drift to drugs being one of them — and the price paid by society.

Mr Lasry told **The Journal** the idea for the film was triggered by a Johns Hopkins University study of the health effects and social costs of unemployment. That study established clear relationships between unemployment, suicide, mental hospital admissions, imprisonment, and "various other pathology".

"We wished to verify the report in Canada," he said, "and the effect of unemployment on people in trouble with the law and with themselves."

The section of the film that deals with drug problems was shot at the Portage Program residence, Lac Echo, Que with senior staff member, Terry McAloon, acting as Portage advisor to the film crew.

The film will be ready for release in March or April.

One million W. Germans 'problem drinkers'

FRANKFURT — Some one million West Germans over the age of 14 consume more than 80 grams of pure alcohol daily and should be classified as "problem drinkers," according to a recent survey here.

The study, carried out by the Marplan Research Institute, an opinion poll organization, described 72% (up to 40 grams of pure alcohol per day) "moderate drinkers," 10% (40 grams to 80 grams daily) as "medium drinkers," and 2% as "problem" or "heavy drinkers."

The latter are found in particularly large proportions — 6% of the age group — among West Germans from 18 to 21.

The survey found no "heavy" drinkers among 14- to 17-year-old teenagers but classified 78,000 West German youths as "medium" drinkers susceptible to alcoholism.

Of those interviewed in a representative poll, 70% of men prefer beer, 71% of women opt for sparkling wine and champagne. Drinking at home, on social occasions, or as a nightcap is preferred by 71%.

Alcoholism is not apparently considered a major social problem by West Germans, to judge from the survey. It ranked fifth behind "crimes of violence," "unemployment," "political radicalism," and "drug addiction."

Asked from what age children and youths should be permitted to drink, 21% said beer should be allowed to those between 14 and 16. Four per cent favor permitting 11- to 14-year-olds to have beer. But 73% said liquor should not be permitted until age 18.

Americans quit weed, health on rise

By David Milne

WASHINGTON — Reductions in smoking and consumption of fatty foods are paying off in better health for Americans, while most Europeans seem unwilling to improve their health by changing their lifestyles, according to the director of the National Heart, Lung and Blood Institute here.

Drop in deaths

Robert J. Levy estimates changes in smoking, eating and other habits are primarily responsible for a striking drop in deaths from heart attacks and strokes — probably saving the lives of 164,000 Americans last year compared to 10 years ago. And stopping smoking has played a major role.

Dr Levy made this statement while visiting the Stanford Heart Disease Prevention Program here.

Improvements

The mortality rate from strokes has fallen 33% during that time and now is decreasing 3% each year.

Heart attack deaths have dropped 20% in the same period, and each year fall an additional 2%.

"This is a relatively unique phenomenon," said Dr Levy. "Western European countries have, at best, steady heart disease-related death rates, and in some countries the rates have actually increased."

He cited improvements in emergency resuscitation techniques and coronary care as responsible for some of the decrease in heart disease mortality.

But the greatest factor in the change is related to changes in lifestyle, he said.

"People are more attentive to blood pressure today," he said. In addition, the proportion of people in the US who smoke has decreased. Smoking has only increased among adolescent females, he said.

According to the latest department of agriculture report, Americans will smoke less this year than they have done anytime during the past 20 years.

No program

This situation is contrasted with European lifestyles, in which risk factors for heart disease "are not being attended to," said Dr Levy. Europeans seem to be smoking as much, if not more, than ever. There is no government directed program to lower blood pressure. And consumption of fatty foods is also high.

...but Europe stays under the haze

By Thomas Land

BRUSSELS — A cloud of blue smoke still hangs over Western Europe — despite vigorous anti-smoking campaigns.

Various information campaigns conducted in the nine member countries of the European Community, and measures introduced to restrict smoking in public places, have failed to cause a particularly startling drop in consumption.

Smoking among women has increased. Men are smoking slightly less than before, and young people show little change.

These are among the disappointing facts placed before a recent meeting of the health ministers of the member countries in Brussels. They responded by commissioning a comparative study on the effectiveness of the anti-smoking campaigns, leading to experimental new campaigns to be directed specifically at young Europeans. They also agreed to seek a common approach to tobacco advertsing.

Only France and Britain are exceptions to the trend projected by the data collected and assembled for the health ministers' conference by the European Commission.

First, the good news.

The European Commission attributes a 3% decline in the number of French smokers to the success of various anti-tobacco information campaigns. For the first time in a decade, sales of tobacco products in France have decreased 1.9%. At the beginning of 1970, 43% to 44% of French adults smoked. By 1977, the percentage had dropped to 40%.

Also in Britain, total cigarette sales fell from 137 billion in 1974 to 124.2 billion in 1977, and the number of smokers dropped from 19.5 million in 1974 to 18.2 million two years later. British smokers are increasingly conscious of the tar content in cigarettes and the average tar level has fallen, according to figures available, from 20.8 mg per cigarette in 1972 to 16.1 mg in 1977.

But the rest of the Community follows a different pattern.

Over the past quarter century, tobacco consumption has remained stable in Denmark although cigarettes have increased their popularity. The percentage of male smokers has decreased slightly but the rising trend among women has continued at the same pace. The number of heavy smokers has also increased. Only teenage boys (15 to 19 years) have smoked less — but surprisingly there is no corresponding decrease among girls of the same age.

Between 1973 and 1976, smoking decreased slightly among the younger and senior age groups in West Germany — but increased among middle-aged people. The introduction of heavy tax increases on cigarettes led to a considerable increase in the sale of cigarette tobacco.

Tobacco consumption in the Netherlands decreased in 1976, largely as a result of an anti-smoking television campaign, the European Commission says. But then cigarette smoking increased once again in 1977. In the long term, there appears to be an increase in tobacco consumption.

The lack of specific statistics in many regions hampers attempts to draw general conclusions. There has been a decline in the total quantity of tobacco sales in Ireland, for example, but it is unclear how that has affected cigarette consumption. Italy has no statistics at all; and the anti-smoking campaigns in Luxembourg and Belgium have been much too recent to offer conclusions.

However, the health ministers agreed the general trend emerging from the available statistics calls for imaginative, vigorous, and coordinated action.

Hence their agreement to compare the effectiveness of the national anti-smoking campaigns. The lessons to be learned from them are to be used in new, experimental campaigns to be aimed at young people and backed by new, Community-wide restrictions on tobacco ads.

UK psychiatrists deliver 'shock' to social drinkers

By Alan Massam

LONDON — British social drinkers received a nasty shock when newspapers published details of a study which warns of the possible serious consequences of modest alcohol consumption.

"One over the four is one too many" is the headline chosen by the normally sober Sunday newspaper, *The Observer*, whose medical correspondent Christine Doyle quoted as "controversial" the report from the Royal College of Psychiatrists (RCP) which put four pints of beer a day as the path, for some, towards alcohol dependence.

The psychiatrists also, apparently, regarded four doubles of spirits or one standard-size bottle of wine as the level beyond which daily regular drinking "may slide into dangerous heavy drinking".

Miss Doyle did not disclose how she gained sight of the RCP's deliberations which still remained unpublished, officially, well into January. She asserted, however, it was a "detailed assessment of the alcohol problem in society today."

Further, she thought the report would be likely to influence opinion on advertising and availability of alcohol and the debate on whether British licensing hours should be extended.

"Given the strong links between a steep rise in alcohol disabilities and a huge increase in per capita consumption of alcohol in the United Kingdom from 5.2 litres in 1950 to 9.7 litres in 1976, there is no alternative, says the report, to 'all of us drinking somewhat less.' "

Miss Doyle gives the RCP's recommendations as "including" the following: that the ways in which employees of industrial or commercial undertakings are pressurized to drink should be reviewed; that preventive programs should be devised for high risk professions or trades; and that leisure activities without drink should be encouraged.

The college also urged, she says that smaller quantities of drink should be provided at official functions; that individuals should be discouraged from providing more than a proposed safe upper limit of drinks when entertaining; that people should not ignore those who drink excessively, and respond with concern as they would for any other potentially dangerous form of behavior; that everyone should review his or her drinking and work out a personal prevention program particularly if the "safe" level is being exceeded.

Attempts by this reporter to obtain a copy of the RCP report met with polite refusal. British psychiatrists certainly will not be hurried.

Clearly, with the recent winding up of the government's Advisory Committee on Alcoholism (final meeting held on Dec 12, 1978) some significant developments can be expected this year.

Philip Morris tells workers they are not to 'feel guilty'

By Thomas Land

LAUSANNE — Philip Morris, the American tobacco giant, has published a leaflet for its employees encouraging them not "to feel guilty for working for a cigarette company."

Written in question/answer form, the leaflet purports to counter scientific evidence linking cigarette smoking with lung cancer, heart disease, and other ailments.

More assertive

Answering whether smoking can shorten one's lifespan, the pamphlet refers to "the fact that smokers and non smokers are different kinds of people". Elsewhere, it describes the former group as "generally ... more assertive, time-conscious, and energetic than non smokers."

It also states "tobacco companies do not encourage young people to smoke," describes nicotine addiction as something comparable to "addiction" to chocolate eating and television viewing, and defines smoking as "an adult custom based on a mature individual's freedom of choice."

PR campaign

The document claims "cigarettes have never been proven ... to be unsafe," and "the funding of health research internationally is handled by the tobacco manufacturing associations in the individual countries."

Three years ago, Philip Morris became the first tobacco company in Britain to launch a public relations campaign challenging the 1962 report of the Royal College of Physicians which identified cigarette smoking as a major health hazard. In the leaflet *Smoking and Health News*, the company published a digest of research conclusions stating light smokers were, in fact, more fit than non smokers.

The leaflet also states: "Despite the presence of warning notices in advertising or on cigarette packages sold in some countries, there are still those who believe that it is their duty to protect us from ourselves." It describes much of the anti-tobacco lobby as "so-called voluntary health associations ... (and) self-appointed crusaders, those who force their self-righteousness on the general public."

Consumer demands

Answering the question, "Do you feel guilty for working for a cigarette company?", the anonymous author of the leaflet states: "No, I don't ... I'm proud to be part of an industry which has continued to grow because of its ability to meet consumer demands ..."

The leaflet was written for Philip Morris employees in Europe, the Middle East, and Africa.

NEXT MONTH:

The evidence is now "overwhelming" that cigarette-smoking is hazardous to health, says the United States Surgeon General's new report on smoking and health.

New Books

by RON HALL

The Alcohol and Drug Commission of British Columbia Accountability System for Funded Agencies

. . . by Marcus J. Hollander, Murray A. Martin, and Barbara E. Downs

The Alcohol and Drug Commission has established a model accountability system for provincially funded treatment agencies. It used the concept of "system of care" to define the types of services required in British Columbia and their interrelationship with each other. The accountability system has three major components; fiscal accountability, client monitoring, and direct agency contact. In addition to describing the operation as it relates to these components, the authors discuss the purpose, development, and implementation of the system, as well as cost.

(The Alcohol and Drug Commission of British Columbia, 805 West Broadway, Vancouver, British Columbia, V5Y 1P9. 1978. 60p.)

Alcoholism and Treatment

. . . by David J. Armor, J. Michael Polich, and Harriet B. Stambul

Based on the Rand Corporation study, this book reports on data collected from alcoholism treatment centres throughout the United States. It suggests that treatment is, in most cases, successful. The study makes no recommendations about specific treatment goals, and it does not suggest that any alcoholic resume drinking. However, it does question the wide acceptance of abstention as the only method of recovery from alcoholism. Social correlates of alcoholism and problem drinking, patterns of remission, and the effectiveness of treatment are topics which are discussed.

(John Wiley and Sons, Inc, 1 Wiley Drive, Somerset, New Jersey, 08873. 1978. 365 p. $16.95)

Alcohol, Other Drugs and Violent Death

. . . by Paul W. Haberman and Michael M. Baden

This book presents a detailed analysis of the relationships between substance abuse and unnatural deaths. It demonstrates that alcohol and other drugs of abuse not only contribute significantly to all violent deaths, but are the most common underlying factor in such preventable fatalities. The authors conducted a study of 1,954 cases investigated by the Chief Medical Examiner's Office in New York City during a one-year period. Of those victims, 800 were alcoholics and over 500 were narcotics abusers, including some 200 with both conditions. The underreporting of drinking or drug problems among these cases is discussed, and patterns of substance abuse by decedents and their close relatives are interpreted.

(Oxford University Press, 70 Wynford Drive, Don Mills, Ontario, 1978. 144p. $16.95)

Methadone Treatment in Narcotic Addiction

. . . by Robert G. Newman

The author presents a comprehensive account of the history, policies, management, and experiences of the New York City Methadone Maintenance and Ambulatory Detoxication Programs, which he directed from their inception in 1970/71 to 1975. These programs had more than 80,000 admissions during this period. The first part of the book presents the rationale for maintenance and detoxication treatment, planning and organization, management, and relationship with the community. Selected policy issues such as voluntarism as a criterion for admission, confidentiality, methadone dosage, and the irrelevance of success are discussed. The second part presents and analyzes data from these programs.

(Academic Press, 111 Fifth Avenue, New York, NY, 10003, 1977. 306p. $19.50)

Loosening the Grip:
A Handbook of Alcohol information

. . . by Jean Kinney and Gwen Leaton

This handbook contains basic information for an alcohol counsellor or other professional confronted with alcohol problems. It is an attempt to synthesize and organize the information from medicine, psychology, psychiatry, anthropology, sociology, and counselling that applies to alcohol use and alcohol treatment. Chapters cover historical aspects, alcohol and the body, definitions of alcoholism, medical complications, effects of alcohol on behavior, effects of alcoholism on the family, and treatment. Special mention is made of the use and abuse of alcohol by women, the elderly, adolescents, and the employed. The book is illustrated and indexed.

(The C. V. Mosby Company, 11830 Westline Industrial Drive, St Louis, Missouri, 63141, 1978. 302p. $8.75)

I'm Black and I'm Sober

. . . by Chaney Allen

This is the autobiography of a minister's daughter who relates her experiences from the soup kitchens of Selma, to the tenements in Cincinnati, and finally to a career as an alcoholism lecturer and counsellor in San Diego. She recalls how the principles and fellowship of Alcoholics Anonymous have been helpful, and includes other practical aids she has developed while helping alcoholics.

(CompCare Publications, 660 Newport Center Drive, Newport Beach, California, 92660, 1978. 294p. $6.95)

NEW MATERIALS FROM ARF

GUIDES

P-151 **DIAGNOSIS AND TREATMENT OF ALCOHOLISM FOR PRIMARY CARE PHYSICIANS** **$1.95**

A 36 page handbook on alcoholism developed for the primary care physician in conjunction with the Ontario Medical Association. A "how-to" guide dealing with identification, diagnosis, short and long-term management in both the medical and psycho-social senses. Invaluable to the medical practitioner.

P-160 **TEN LESSON PLANS FOR GRADES 7 AND 8** **$7.95**
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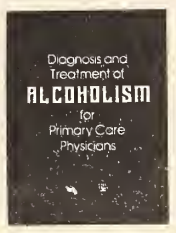
The program consists of two sets of 10 lesson plans. Each lesson deals with a separate topic and can be used independently. Developed in conjunction with the Toronto Board of Education. The lesson plans provide the teacher with as much information concerning alcohol and the process of teaching about alcohol as is possible. Includes suggestions for A/V and other materials to enhance the program. The Ontario Ministry of Education has reviewed the lesson plans and found them to fit Ministry guidelines.

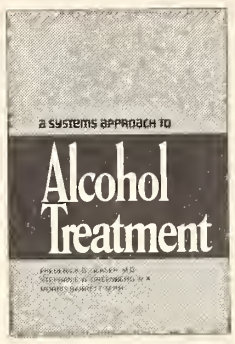


BOOK

A SYSTEMS APPROACH TO ALCOHOL TREATMENT

Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.
$14.95

A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



VIDEO CASSETTE

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Content: What is marijuana and what does it look like?
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Effects compared to alcohol?
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PAMPHLETS

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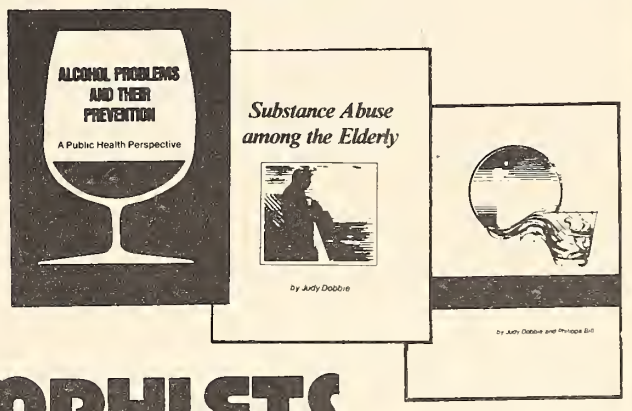
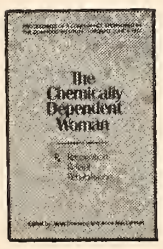
P-111 **ALCOHOL PROBLEMS AND THEIR PREVENTION —A PUBLIC HEALTH PERSPECTIVE** **40¢ each**





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THE CHEMICALLY DEPENDENT WOMAN

The published presentations resulting from a conference on women's issues, hosted by the Donwood Institute, Toronto. A distinguished group of presentors, including Dr. Gordon Bell and Ms. Jan Du Plain, address issues of usage, patient and physician perspectives, treatment trends, and new directions for women.

P-266 **$4.95**

SOLVENTS, ADHESIVES, AND AEROSOLS

The published presentations resulting from a seminar hosted by the Ministry of Industry and Tourism and the ARF on the use and misuse of these substances. The volume contains papers on historical review, legal considerations, community approaches to treatment, industrial perspectives, and a keynote address on international trends by Dr. Sidney Cohen of U.C.L.A.'s Neuropsychiatric Institute.

P-267 **$14.95**

INTERNATIONAL COLLABORATION: PROBLEMS AND OPPORTUNITIES

Proceedings of a two-day international seminar marking the designation of the Addiction Research Foundation as a collaborating centre of the World Health Organization.

Areas of discussion include: the epidemiology of alcohol and other drug-related problems, control strategies, and international collaboration in drug abuse programs.

PROCEEDINGS

Order by catalogue number from: **MARKETING SERVICES, ADDICTION RESEARCH FOUNDATION**
33 RUSSELL STREET, TORONTO, CANADA M5S 2S1
TELEPHONE: (416) 595-6056

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Alcohol, The Drug

Subject Heading: Alcohol and alcoholism overview, alcohol pharmacology.
Details: 15 minutes, ¾" U-Matic videotape, color, sound.
Synopsis: Information on what alcohol is, how it is made, how it affects the body, the results of misuse, and the elimination of alcohol from the body are explained with the aid of graphics. Interspersed are historical examples of uses of alcohol. Finally, an explanation regarding alcohol dependence and what can be done about it are given.
General Evaluation: Very good (5.0). This contemporary videotape was informative, of good technical quality, and of suitable length to make it a good teaching aid. Broadcast was recommended.
Recommended Use: Of benefit to those 15 years of age and older.

Alcoholism In Industry

Subject Heading: Employee Assistance Program.
Details: 16 minutes, 16 mm, color, sound.
Synopsis: In this lecture, Father Martin pleads with industrial organizations to institute employee assistance programs. He lists some of the problems a drinking employee causes in the work setting and urges management to help problem drinkers. Father Martin emphasizes the importance of getting professional help in setting up these programs.
General Evaluation: Fair (3.3). A contemporary film with a clear message, it received moderate ratings in all the other categories. The film's elementary approach limits its use in the implementation of employee assistance programs.
Recommended Use: Likely to be of benefit in promoting interest in employee assistance programs.

Teenage Turn On

Subject Heading: Youth and alcohol, drugs and youth.
Details: 37 minutes, 16 mm, color, sound.
Synopsis: The film examines America's attitudes toward alcohol from the 1920s to the 1960s. For many years, youth's involvement with alcohol and other drugs has been a cause for concern. Throughout the 60s, young people experimented with various drugs but in the 70s most have returned to alcohol as the drug of choice. The film finds that most of the young drinkers nowadays are multiple drug users. A model for youthful rehabilitation is shown. After detox, group therapy and peer relationships become primary treatment objectives. Two school programs on drug education are shown, and finally a checklist is provided for parents to see if their teenager is in potential danger.
General Evaluation: Poor (2.1). Although this film was contemporary, it was considered a poor teaching aid.
Recommended Use: The film seemed to be intended for audiences of 15 years of age and older, but the group did not recommend its use for any age group.

Positions Available

DIRECTOR, SUBSTANCE ABUSE

Masters or Ph.D in psychology, social work or related field. Supervisory and clinical experience preferred. Supervision of services and staff activities provided by alcohol, methadone and drug-free outpatient programs.

Salary: Negotiable

Contact: Personnel Manager, Central Washington Comprehensive Mental Health, Yakima, WA 98907 (509) 575-4274.

Closing Date: March 1, 1979.

THE PAS HEALTH COMPLEX INC.
requires a
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for the position of Director of Rosaire House. Rosaire House is an accredited 28 bed detoxification and rehabilitation center offering a wide range of chemical abuse treatment programs and services.
As a member of the senior administrative team of the health complex the Director is responsible for the day to day administration of the treatment facility and the programs.
The successful candidate will have successfully completed a recognized course in health care administration (H.A. or H.O.M.), three years experience in health care administration and a proven management record.
Previous experience in working with chemical abuse treatment programs would be an asset.
Salary is commensurate with qualifications and experience. An attractive range of fringe benefits is available.

Please submit complete resume to:
Mrs. M. Seguin,
Personnel Director,
The Pas Health Complex Inc.,
Box 240,
The Pas, Manitoba.
R9A 1K4.

Queen's University requires
a
RESEARCH ASSOCIATE

Queen's University has an opening for a social scientist for the position of Research Associate. The project deals with agency responses to alcohol abuse problems. The successful candidate will be responsible for instrument development, data collection, data analysis and report preparation. In addition, the development and maintenance of working relationships with a number of medical and social agencies will be necessary.

An advanced degree in one of the social sciences is required. Candidates should have experience in alcohol abuse treatment research, epidemiology or public health.

This is a grant funded, two year position. Starting date will be April 1, 1979. Salary is $16,000 per annum.

Interviews with selected candidates will be held in Kingston and Toronto. Applicants should submit their curriculum vitae and the names of referees by February 15 to:

Employment Interviewer
Personnel Services
Queen's University
Kingston, Ontario
K7L 3N6

Coming Events

In order to provide our readers with adequate notice of forthcoming events, send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

Detox Training Program — Feb 5-9, March 26-30, April 30-May 4, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

Our Children Our Future — April 9-11, Toronto, Ontario. Information: Ontario Association of Children's Aid Societies, 663 Yonge St, Toronto, Ont, M4Y 2A4.

70th Annual Conference Of The Canadian Public Health Association — June 18-22, Winnipeg, Manitoba. Information: Mr G. H. Dafoe, Executive Director, CPHA, 1335 Carling, Suite 210, Ottawa, Ont, K1Z 8N8.

Canada's Safety Council's 11th Annual Safety Conference— Sept 30-Oct 3, Quebec City. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ont, K1G 3V4.

United States

International Conference On Treatment of Addictive Behaviors — Feb 20-24, Taos, New Mexico. Information: M. R. Miller, PhD, University of New Mexico, Albuquerque, NM, 87131.

Cruising Medical Seminar On Alcoholism — March 2-13, "Statendam" Sailing from Florida. Information: John A. Ewing, MD, Director, Center for Alcohol Studies, University of North Carolina, Chapel Hill, NC, 27514.

Mood Altering Drugs — Risk and Benefit — Mar 16-17, Virginia Beach, Virginia. Information: Terri Pope, Mental Health Programs, Old Dominion University, Norfolk, Virginia, 23508.

Alabama School Of Alcohol Studies — March 20-23, Tuscaloosa, Alabama. Information: Peter Balsamo, Director, Continuing Education in Human Services, University of Alabama, PO Box 2967, University, AL, 35486.

American Medical Society On Alcoholism — April 26-May 2, Washington, DC. Information: J. G. Chen See, MD, AMSA, 733 Third Avenue, New York, NY, 10017.

First National "Women in Crisis" Conference — May 17-19, New York City. Information: Jane Velez, Conference Administrator, "Women in Crisis", 444 Park Avenue South, New York, NY, 10016.

14th Meeting — Association Of Halfway House Alcoholism Programs — June 3-7, Lincoln, Nebraska. Information: AHHAP, 786 East 7th St, St. Paul, Minnesota, 55106.

Ohio Drug Studies Institute 1979 — June 11-15, Columbus, Ohio. Information: ODSI Training/ Division of Mental Health, 13th Floor, Room 1346, 30 East Broad St, Columbus, Ohio, 43215.

21st Annual International School of Alcohol Studies — July 15-20, Grand Forks, North Dakota. Information: F. Wittmann, Conference Coordinator, University of North Dakota, Continuing Education, Box 8277, University Station, Grand Forks, North Dakota, 58202.

6th National Drug Abuse Conference — Aug 26-30, New Orleans, Louisiana. Information: NDAC '79, 115 S Chestnut Street, Lafayette, LA, 70501.

4th World Conference Of Therapeutic Communities — Sept 16-21, New York City. Information: Charles Devlin, Coordinator, Daytop Village, Inc, 54 West 40th Street, New York, NY, 10018.

National Conference On The Problems And Preventions Of PCP Abuse — Nov 3-4, San Francisco, California. Information: Stephanie Ross, Haight Ashbury Training and Education Project, 409 Clayton St, San Francisco, CA, 94117.

Abroad

Fifth Scottish School On Alcoholism — April 1-6, Ayr, Scotland. Information: Mr G. E. Isles, Executive Director, Scottish Council on Alcoholism, 34 Queen Street, Edinburgh EH2 1JX, Scotland.

International Conference On Animal Models In Alcohol Research — June 4-7, Helsinski, Finland. Information: John David Sinclair, Research Laboratories of the State Alcohol Monopoly (ALKO) Box 350, SF-00101 Helsinski 10, Finland.

25th International Institute On The Prevention And Treatment Of Alcoholism — June 18-22, Tours, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 10001 Lausanne, Switzerland.

Third World Congress Of The International Commission For The Prevention Of Alcoholism And Drug Dependency — Aug 26-31, Acapulco, Mexico. Information: ICAP Executive Director, 6830 Laurel Street, NW, Washington, DC, 20012.

10th International Conference On Health Education — Sept 2-7, London, England. Information: The Conference Centre, 43 Charles Street, Mayfair, London W1X 7PB, England.

International Conference On Alcoholism And Drug Dependency — Sept 3-7, Tegucigalpa, Honduras. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

9th International Institute On The Prevention And Treatment Of Drug Dependence — October, Madrid, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1st Pan-Pacific Conference On Drugs And Alcohol — Feb 26-Mar 7, 1980, Canberra, Australia. Information: Pierre Stolz, AFADD, PO Box 477, Canberra City, A. C. T. 2601, Australia.

26th International Institute On The Prevention And Treatment Of Alcoholism — June 9-14, 1980, Cardiff, Wales. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

10th International Institute On The Prevention And Treatment Of Drug Dependence — June 15-20, 1980, Cardiff, Wales. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

33rd International Congress On Alcoholism And Drug Dependence — Sept 22-26, 1980, Sao Paulo, Brazil. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

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Positions Available

HEAD OF MEDICINE

The Clinical Institute of the Addiction Research Foundation of Ontario, a teaching hospital of the University of Toronto, is seeking a qualified physician for the position of Head of Medicine. The successful candidate will be a qualified internist and will have had considerable clinical experience and an interest in medical education and research.

The candidate should be licensed in the Province of Ontario or should have the qualifications to obtain such license. While this individual shall serve as Head of Medical Services of the hospital, he/she shall also collaborate in the coordination of medical and other clinical services. He/she shall have demonstrated an academic achievement to merit a senior faculty appointment in the Department of Medicine, University of Toronto, and shall be responsible for the post-graduate education programs in medicine for the Institute.

Salary will be commensurate with training and experience.

Applicants are invited to forward curriculum vitae to:

Dr Yedy Israel
Chairman, Search Committee
Clinical Institute
Addiction Research Foundation
33 Russell Street
Toronto, Ontario
M5S 2S1

HEAD, SOCIO-BEHAVIOURAL TREATMENT RESEARCH

A senior researcher is being sought by the Addiction Research Foundation to assume the position of Head, Socio-Behavioural Treatment Research reporting to the Director of the Clinical Institute.

In addition to being actively involved in his/her own research projects this individual will have primary overall responsibility for the socio-behavioural treatment research programme of the Clinical Institute. It will be his/her responsibility to ensure the development and operation of a scientifically sound, relevant, balanced, and integrated programme which will have maximal impact upon treatment research and practice in Ontario and elsewhere. In this capacity he/she will have managerial responsibility for the four senior scientists who will head research programming in Behavioural Intervention, Psychosocial Intervention, Health Care Development, and Pharmacological Intervention, and will represent those areas on the Institute's Policy Advisory Committee. He/she will work closely with the managers of the Clinical Institute's socio-behavioural treatment programmes to ensure the effective articulation of these programmes with the ongoing treatment research programmes in the socio-behavioural area.

The successful candidates will have a PhD or equivalent with considerable research experience, and a good record of publications in the field of alcohol and drug dependence or a closely related area.

Applicants are invited to forward curriculum vitae to:

Dr Joan A. Marshman,
Chairman, Search Committee,
Addiction Research Foundation,
33 Russell Street,
Toronto, Ontario
M5S 2S1

Drugs, cults–paradoxical promises

Without a vested interest in perpetuating society, children are set up for alienation, involvement with drugs, and the pull of the fringe religions, warns **Dr Saul Levine** *in this interview with* **Donald Gregory Bastian.** *Dr Levine is a psychiatrist at the Hospital for Sick Children, Toronto, and teaches at the University of Toronto. In the 1960s, he worked in addictions in the Haight-Ashbury area of San Francisco. One of a series of special International Year of the Child articles.*

Worried about the possible bandwagon effects of International Year of the Child, Dr Saul Levine, Toronto, calls for an emphasis on children's responsibilities along with the concern for their rights. (Photo by Junko Yamamoto)

Dr Levine, you have made a connection in your research between the reasons adolescents take drugs and the reasons they join cults. Could you elaborate?
During the 60s, and to some extent now, the drug scene had as much intensity, and a kind of quasi-intellectual and emotional support, as any kind of cult has today. It was not just a question of somebody taking a drug like marijuana or LSD. There was a superstructure, a basis of support in the community.

In the early 70s, I did a study on psychological and social aspects of amphetamine abuse. We interviewed more than 200 young people who were into intravenous amphetamines. The street scene was booming at the time and a lot of those people were being self-destructive. I continued to work in a clinic with kids in other aspects of the drug scene. Then I did a study on a couple of hundred young people in communes. That was the popular rage in the early 70s — alternate lifestyles communes.

In the meantime, I have been doing clinical work with alienated kids and, most recently, studies of kids in the fringe religious groups.

What I've found is that those groups are not different. The kids were doing those activities for the same bloody reasons.

This wasn't something you suspected ahead of time?
No, no. My theoretical orientation evolved. The fact is that if I go over the conclusions of every one of my studies, I come up with the same point. Now, this can be over-sold, especially when we're talking about the drug scene. But, for whatever it's worth, the young people all engaged in certain activities that would make them feel better, to put it in purely hedonistic terms.

That feeling of bodily pleasure is enough to get somebody in the drug scene, but not enough to keep him there. What keeps him there is doing it in a group, doing it with some kind of shared spiritual and emotional values and experiences. It's that shared emotional experience and shared value system, almost a belief system, that has struck me right through my research. I have tritely called it "believing and belonging."

Presence or absence of a belief system, and the presence or absence of a strong sense of communality, will often determine into what particular scene a young person goes. That scene may be stamped by us as detrimental, depending on what side of the fence we are on. If, for example, I am a communist, and for these very reasons my son joins the Communist Party of Canada, I won't think anything about it. If I am a raving capitalist and my son becomes a communist, I'll think, my God, what's happening to him?

Is there a further connection between drugs and cults, in the reasons behind going into the different scenes?
Well, another aspect to these movements that I have seen invariably, with every one of these people that I've studied, is that when they are heavily involved in a scene, no matter what it is, once they have that sense of value system, of belief system that they are really on to something different and special, and that makes them special, they achieve a bodily euphoria, a sense of well-being. They also achieve a major increase in their self-esteem.

Now, I have to emphasize that kind of thing occurs in a variety of potential scenes and it certainly occurs in the therapeutic realm. It certainly occurs with certain kinds of political groups, in the cults and, in large part, in various aspects of the drug scene — the emotional high, the emotional feeling of being part of a group that is different from the mainstream.

This matter of believing and belonging, is that the distinction you make in your work between traditional psychiatric treatment and say, therapeutic communities?
Oh, yes. As a matter of fact, with addicts who are already past the point of having some degree of choice, at least for some of them, use is being made of believing and belonging in so-called intentional social systems. Synanon has reached epic religious proportions but I think it is very destructive. When I worked in California, I used to go to their meetings, and it was a revelation what would happen there. They would specify that it was non-religious, but they would have the closest thing I've ever seen to a kind of revival night. They would take one person and emotionally and verbally rip him to shreds. You could feel the electricity in the air. That person, rather than breaking down, would, in fact, come closer to the group. Jim Jones used this in his religious group.

One of the things about most of these religions is that they are drug free, because what is interchangeable, the chemical high, is easily, and I underline, easily, replaced by the emotional high the group gives you, by the belief system and the sense, the powerful sense, that you don't need the drug anymore. You can achieve that high in a group.

How do you relate this to psychiatric treatment of young people in drugs or cults?
Treatment tends to be narrow. Treatment of drug addictions is too often looking at one aspect of youth behavior or adult behavior for that matter — and that's the drugs themselves. The drugs situation has reached the point where it has to be looked at. You can't pretend that it is gone.

But, on the other hand, it fades if you don't get a gestalt, if you can't stand back and say, my God, that drug scene is just one aspect of human behavior that is similar to other kinds of behavior that kids can get into, that their parents *aren't* concerned about.

This is grandiose, but sometimes I feel like a voice in the wilderness, because I think there are some pretty scary times ahead. Partly because of the economic situation. We have double-digit unemployment here in Canada. That is approaching 50, 60, 86% in some parts of Toronto for kids in the age groups of 16 to 25. These are youth at their most physically healthy, their most potentially idealistic. They're strongest in terms of just pure body strength, but there is nothing for them.

If there are no jobs, and school has not provided them with a transition from school to work, and there is nothing for them to do, so, well, why not go into the drug scene, or why not join a cult, or why not join a revolutionary movement, or why not do something where the answers that you have to the questions that you have, are provided?

How do you deal with families where these problems have already risen?
I've had this happen dozens of times. A kid comes in as a favor, finally, to his parents and they see him sitting there and he is in a state of just absolute euphoria. He's blissed out of his skull and his parents are saying to him: What are you talking about? You're programmed, you're brainwashed, you're not happy — you think you're happy.

And then he says to them: You're telling me my brand of happiness isn't as good as yours. Are you telling me that you are happier — he points his finger at his parents — that you want me to be as happy as you?

Now they think to themselves: they're both in their 50s and, like anybody who's in real life, there's a lot of pain, they've been through various crises. And, when they're asked a very direct, concrete question, of course they can't say that they are unadulteratedly happy, so he has them on the spot.

And he says: Well, I *am* that happy. Or, he starts pointing very nasty fingers at their foibles: You're so happy you have a cocktail — or five cocktails — every night when you come home from work, or you're on the verge of divorce. You're so happy you're playing around, Mom, or you're playing around, Dad.

I'm talking about relatively good families that things happen to from time to time. Well, the kids exploit that. They say: I don't want that to happen. I'm in a religious group where I don't need drugs and I don't play around with women and I don't do this and I don't do that. How can you say I'm not happy? How can you *dare* say I'm not happy?

How do you see the drug scene in the 70s, particularly in light of this being the International Year of the Child?
Well, drug-taking in the 70s doesn't have that flower child, revolutionary flavor it had in the 60s. They thought drugs were salvation then. It's more narcissistic now, and I think that's detrimental in the sense that people are into bettering themselves — but hedonistically.

Health fads and so on?
While health foods and jogging are on one side of the coin in the 70s, there's also the human potential movement and, in a sense, it's every person for himself or herself. There's not as much caring.

And there's something else about the drug scene in the 60s that relates to the cults of today. Within the group, there is a great deal of what they see as love and affection and support and sharing, but a lot of non-caring outside the group.

That's what makes the cults so strong?
Oh, it's tremendous. The big paradox of the 70s is that caring happens within the group, but outside the group there's a lot of irresponsibility and independence and egocentrism.

THE BACK PAGE

What are your concerns during the International Year of the Child?
Kids' rights have to be protected and education has to be a right. But if we're going to fight the drug and cult scene, kids will have to be inculcated with a sense of believing in their society and in themselves — that there is a purpose in society.

So they have to have a sense of continuity, not just life moment by moment.
Yes, if they don't have that vested interest in perpetuating society, then why not do something detrimental, and then you have the anti-social activities or the hedonistic activities.

I think the childrens' rights emphasis is good this year but I am wary about the bandwagon effects. It's like International Women's Year — what happens at the end of the year? Has anything been accomplished?

We should look at how kids have been deprived but, at the same time, at what contributions they have to make to society. Especially adolescents. They should be thinking in terms of responsibilities.

The focus seems to be adults saying we've got to protect children's rights, but perhaps we should say, what are children's responsibilities in the Year of the Child? What should they do postiively?
Yes, but we're not really to that point yet — the point of asking what children and adolescents should do. Let's even start looking at that. People haven't begun to be concerned about that yet.

1979 International Year of the Child

Political winds shift on pot decrim

By Jeff Carruthers

OTTAWA — In a surprise development, Liberal, Conservative, and New Democratic spokesmen have agreed that speedy House of Commons passage be given legislation to eliminate the criminal aspects of simple marijuana possession in Canada.

So far, however, nothing more has happened to give Canadians who are interested in seeing marijuana crimes no longer result in jail terms or criminal records the hope they had been reaching for.

Only the tiny Social Credit Party has said it is unwilling to have a decriminalization bill go through Parliament quickly.

Nevertheless, the political winds seem to be shifting noticably in the shadow of the upcoming federal election. Contrary to Liberal party insider views that marijuana is an issue to stay away from, both the opposition Conservatives and the New Democrats now seem interested in getting the drug issue straightened around, and fast.

Behind the most recent concern is the feeling that too many young Canadians are being saddled with criminal records after being caught with the cannabis, even when it's a first offence. Both sides of the House believe cannabis should still be illegal and that greater efforts and more severe penalties should be aimed at traffickers and importers.

The recent political accord emerged as a result of a question in the Commons by Conservative youth critic Paul Dick, who criticized the government's failure to deal with the cannabis issue as promised almost seven years ago.

(See — Lalonde — page 2)

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The Journal

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Some silver in the lining

US drug agencies face cuts

By Harvey McConnell

WASHINGTON — Alcohol and drug agencies in the United States face a direct 10% cut in federal funds for the next fiscal year and a possible new system of doling out the monies which could cripple their services even more.

One of the proposals in US President Jimmy Carter's 1980 budget is to switch the present system of categorical formula grants to block grants. This system would cover not only alcohol and drug, but mental health programs as well.

Instead of funding being channeled through the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute for Mental Health (NIMH), the monies would go into a general pot with each state government determining how much is given to each agency.

Officials in the drug and alcohol field say mental health is now a "glamor issue," following the report of the Presidential Commission on Mental Health, and many members of the public still consider drug abuse illegal, and alcohol abuse immoral.

There is some silver in the lining: research money for NIAAA will go up from $22 million to $25 million, and for NIDA from $48 million to $50 million. Research for mental health will zoom up from $133 million to $160 million.

Although NIDA gets an extra $2 million for research, this will now have to include investigations into smoking, which is now under the institute's aegis. Some of the cuts in funds will be for NIDA and NIAAA funded training programs for workers in the field.

The cut in the budget to $100 million for all three agencies is not unexpected: President Carter is proposing slashes in all parts of the national health program.

One legislator who has said he

(See — Workers — page 2)

Carter hits trafficking

WASHINGTON — The United States expects even more cooperation from foreign governments in fighting drug trafficking, according to President Jimmy Carter.

In his State of the Union message to Congress, President Carter said this year emphasis will be put on behavior of people who turn to drugs and (we) "will stress financial investigations as a means of prosecuting those individuals responsible for the drug traffic, and will rely heavily on enlisting foreign cooperation in the overall drug program.

"These efforts should further our success in controlling drug abuse both in the United States and abroad."

He added: "Seizures of illegal drugs are at their highest level ever. Improved coordination and cooperation among federal agencies have resulted in a more effective drug program without major budget increases."

BC plan illegal, delegates charge

By Tim Padmore

VANCOUVER — Delegates to an international symposium on the Female Offender here have called on the British Columbia government to repeal legislation providing for compulsory treatment of narcotics addicts.

An overflow plenary session voted 60 to 6 in favor of the repeal resolution. There were close to 500 registrants.

The resolution says compulsory programs like the one now in effect in BC are "illegal invasions of civil rights" and undermine voluntary programs. It asks that the money allocated for the compulsory plan be used for voluntary programs that "show genuine respect for the personal liberty and personal needs of drug users."

A substantial number of delegates abstained from the vote — 39 in all. One abstainer explained that as a civil servant he felt he could not directly challenge the BC government, although he would like to vote in favor.

The motion reached the floor only after a struggle with symposium organizers who argued that there was no space in the program for presentation of resolutions.

Conference co chairman C. T. Griffiths, a Simon Fraser University criminologist, told **The Journal** emphatically that the vote was unofficial and represented the opinion of only a minority of conference registrants.

Marie-Andree Bertrand, leader of the group that put forward the heroin resolution, along with a number of others dealing with women and crime, said the delegates were anxious to show there is support from outside the province for those opposing the plan.

Dr Bertrand, a University of Montreal criminologist and former LeDain commissioner, said it was only an hour beforehand that the group learned they would be allowed to present the resolutions.

Also passed, by near unanimous votes, were motions urging decriminalization of all forms of drug use and calling on both levels of government to promote community drug treatment facilities to supplement ineffective prison programs and to steer released inmates into them.

VANCOUVER — The British Columbia compulsory heroin treatment plan has been chopped in half because of a shortage of addicts, **The Journal** *learned at press time.*

Instead of accomodating 2,500 addicts in its first year, the program is being scaled down to take only 600 to 1,000. And the initial $16 million a year budget is being slashed to between $8 and $9 million.

Alcohol and Drug Commissioner John Russell announced the changes as departmental budget estimates for this fiscal year were being prepared for the legislature. He said the cuts follow "reassessment of the build up of our case load."

Drinking drivers TV stars

VANCOUVER — Drinking drivers in parts of British Columbia now face the embarrassment of seeing their drunken antics replayed on television in court.

Police in Vernon started the camera rolling and succeeded in convincing a provincial court judge to accept in evidence videotaped recordings of the accused's behavior when charged.

In February, police in the town of Quesnel announced they too would begin using the video recorders.

Authorities hope the TV displays will boost the conviction rate, convince more drunk drivers to plead guilty, and, most optimistically, discourage others from drinking and driving in the first place.

INSIDE

March Quote

At the speed of light, you're not going anywhere. You don't have anymore goals or directions.

Marshall McLuhan exclusive interview
Pages 4, 5

* * *

'Slow-motion suicide'

US Surgeon General's Report on cigarette smoking

Pages 8, 9

BC approach 'incongruous on street'

Rights issues perk up on heroin plan

VANCOUVER — British Columbia's compulsory heroin plan is "a beautiful opportunity" to find out to what extent different methods of treating heroin addiction really work, corrections experts were told here.

Ray Cohen, director of treatment for the plan, made the remark during a panel discussion at an international symposium on the Female Offender.

"We're going to begin to find out" how well different techniques work, he said. "It's a beautiful opportunity to begin to be able to make some significant statements about treatments."

Another panelist said the fact that the effectiveness of treatment is uncertain makes the plan unjust.

"It's foolish to claim to have a program that will work, but to impose it on someone is sheer injustice," said Don Brown, a University of BC philosopher representing the BC Civil Liberties Association.

Mr Cohen replied that civil rights have a different meaning to drug addicts.

"The principle you're defending is incongruous in the reality of the street. The intent of the plan is that you will ultimately restore civil liberties to persons who have been deprived of them."

To which a member of the audience replied: "You may not be mean, but (you) bureaucrats scare the hell out of me."

Bob Grove, program administrator of the California Rehabilitation Centre at Corona, said his state's compulsory heroin treatment has had some positive effect.

Although the program seems to have little effect on the incidence of later drug use, it has apparently had some influence on the severity of later use, he said.

"It's not a question of being cured, it's a question of living a more viable life."

In one study, a group of 200 people who had escaped commitment because of a technical error in their paperwork were compared with 200 others who went through the program. The study group averaged 90 days more per year of incarceration, the death rate was four times higher, and drug use was heavier.

But overall, only a quarter of the inmates are cured after a spell at Corona, he said, cure being defined as two years of clean urine tests.

The California heroin legislation, he said, makes no pretence of being for the good of the addict, stating specifically in a preamble that its aim is to clear addicts from the streets.

Panel chairman Ken Stoddart, a UBC sociologist, wondered why the government is "spending millions of dollars on people who don't want to be helped when there are many people who do want help."

Mr Cohen agreed there are many areas such as alcoholism services that would benefit from support like that being lavished on the heroin program. "If I could wave my magic wand I would do it."

Mr Stoddart said a social class bias is operating. If heroin were widely used, not by the poor and criminal elements, but by middle-class students and professionals "would we then rush to decriminalize heroin like we are marijuana?" he asked.

Drug policy toughens for 1980 Olympics

LONDON — A much tougher line on drug use by athletes who take part in the 1980 Olympic Games will be taken by authorities, warns Lord Killanin, president of the International Olympic Committee.

The "alarming increase" in drug taking means that Olympic officials in Moscow, site of the summer games, and Lake Placid, NY, site of the winter games, will do their utmost to see "the most up-to-date tests take place," he added.

Lord Killanin said use of anabolic steroids, by many athletes taking part in field events, "is tantamount to cheating."

He expressed concern that drugs are being used to retard puberty in some sports, mainly gymnastics, "where it is advantageous to be a young girl."

Many coaches and trainers from Western countries charge that East European officials use the drugs on young women who often look like budding adolescents when they are, in fact, 17 and 18 years old.

Lalonde caught off guard

(from page 1)

Justice Minister Marc Lalonde, who recently revived the government's consideration of the marijuana legislation, seems to be trying to divert the criticism with a comment that the Liberals would be "very happy" to see whether speedy passage of the bill could be guaranteed by the opposition.

Mr Lalonde, who as health minister first tried to get cannabis legislation through Parliament several years ago, has always maintained it was the stubbornness of the opposition in blocking the bill and not the more obvious reluctance of the Liberal government to see the law changed that had led to the lengthy delays.

However, this time, the opposition parties seemed to catch him off guard. And Conservative leader Joe Clark and NDP leader Ed Broadbent both said they would support legislation to decriminalize certain marijuana crimes. Mr Clark taunted Mr Lalonde, saying if the Justice Minister was really serious, "he should move quickly."

Mr Clark said that while his party would like to see some debate, the Conservatives would deal with such a bill relatively quickly. He added — and has subsequently raised the ire of some critics of proposals to ease up on marijuana penalties — that the Conservatives would prefer to spend more time on the bill but felt their backs are to the wall with an election looming.

A couple of days later, however, Mr Lalonde said he did not have high hopes Parliament would move quickly and that therefore he didn't want to raise false expectations.

In the original go-round with Mr Dick, Mr Lalonde rejected as overly simplistic the suggestion cabinet could pass special orders moving marijuana to a less stringent schedule under the Food and Drug Act from the Narcotic Control Act.

The Liberals have maintained that the next cannabis bill will be similar to a Senate version passed several years ago. However, the latest drug reform exercise in Ottawa seems to be much broader than just cannabis and could include amphetamines and drug enforcement rights.

New NDC meets in August

WASHINGTON — The National Drug Congress, formed by break-away groups from the National Drug Abuse Conference, has been incorporated in the District of Columbia and will hold its first conference Aug 26-30 in conjunction with the annual conference of the Alcohol and Drug Problems Association.

Officers who will serve until the August meeting are Rev Richard Gilmore, chairperson, and Frank Espada, Ron Gaetano, and Claire Jones. The NDC has secured enough private financial backing to hire staff and begin plans for the conference.

Trafficker's insurance cancelled

VANCOUVER — Officials of a government insurance plan cancelled a man's house insurance after reading a newspaper report that he had been charged with trafficking in marijuana.

The officials feared the man might be the target of underworld retaliation, perhaps a firebombing, because of his involvement in drug trade.

These facts were alleged before a board of inquiry initiated by the British Columbia Human Rights Branch.

The inquiry is investigating a complaint by Robert Heerspink of Sidney that the Insurance Corporation of BC in 1976 cancelled insurance on rental property he owned in Sidney.

ICBC underwriter Colin Thomas testified that after he received a clipping reporting Mr Heerspink's upcoming trial he recommended the insurance be cancelled primarily because of "the possibility of retaliation by others in the drug trade with whom Mr Heerspink might have had some bad dealings."

John Hogarth, a University of BC law professor and a former chairman of the BC Police Commission, testified that distribution of marijuana at the lowest level of the trade "is essentially an amateur operation."

Workers hope for delay

(from page 1)

will fight to keep categorical formula funding is Senator Harrison Williams, chairman of the Senate human resources committee, and under which is the subcommittee dealing with alcohol and drug abuse.

Senator Edward Kennedy has launched a fight already against all cuts in the health program.

However, for many legislators and bureaucrats there is another side of the coin. By having the states take over allocation of funding it takes them off the hook of deciding who gets what.

The effect of block grants would vary from state to state. In some, the federal funding is a major source of income, while in larger states like New York, Pennsylvania, and California, the total budget derived from categorical funding is much lower.

However, even in the larger states a sudden cut in federal funding means the state will have to pick up bills it had not anticipated.

In many states, the alcohol and drug agencies are lower in the pecking order than mental health, and more often than not the heads of the agencies are appointed at the pleasure of the governor.

The hope is that pressure from legislators might delay changing the funding system, at least for this year.

Turn a cold ear to those silly, silly rumors

By Wayne Howell

Since it upholds the standards of responsible journalism, **The Journal** does not report silly rumors. This is a good thing, since responsible publications should not dignify such rumors by allowing them to appear in print. But, in a way, it is a bad thing, because often it is only when such rumors are exposed in print that their inherent silliness becomes apparent to all:

Take, for instance, the rumor that the British Columbia government plans to force the 13,493 intoxicated drivers apprehended in Vancouver during the past Christmas season to become "compulsory pedestrians" for the next three years. Such a silly rumor — what civilized government would treat errant citizens in such a cruel and unusual manner!

Furthermore, there is absolutely no truth to the story that the BC Alcohol and Drug Commission was forced to destroy 10,000 full-color glossy posters announcing the new three-year compulsory treatment program for heroin addicts because of a Freudian-type error at the printer's shop: the words "heroin addict program" did not appear on the 10,000 posters as "heroin addict *pogrom*" as alleged by the malicious rumormongers.

Another insidious rumor from the west coast has it that there are certain individuals who will be able to gain exemptions from the draconian compulsory treatment plan because of past "related experience". This is not true. The new law is going to be enforced with scrupulous fairness to all: people who spent three years in the BC interior in the 1940s being treated for their Japanese-Canadianness are not exempt, they are just as eligible as anyone else.

It would be pleasant to report that malicious rumormongers exist only on the windward side of the Rocky Mountains but alas, that is not the case. Ontario has its share also. A most scurrilous rumor of recent months is that the Ontario provincial government hired a mobster from Newark, New Jersey, as a consultant designer for the new Lottario provincial lottery. Now it is true that the new provincial gambling game does appear similar to the "numbers racket" that has always flourished in black American ghettos throughout the eastern United States but the similarity is only coincidental, as a dispassionate analysis clearly demonstrates: in the ghetto version of the numbers game a person selects three numbers from a set of 10 so his chance of winning is one in 1,000; in the Lottario version a person selects six numbers from a set of 39 so his chance of winning is one in 137,231,006,679. It is obvious that no mobster acting in a consulting capacity could have thought up such a scheme for extracting money from the poor; such a scheme could only be devised by revenue hungry bureaucrats. Furthermore, "numbers runners" are traditionally recruited from the criminal element and there has never been any suggestion that Ontario lottery ticket distributors come from the criminal element — the only suggestions have had to do with the question of political patronage. I could go on and on, but as you can see, the rumor is completely unfounded.

Ottawa, of course, is no stranger to rumors, especially when a federal election is approaching. The latest rumor — that federal Liberals are just trotting out their decriminalization proposals for marijuana as pre-election bait and plan to shelve the whole thing as soon as the election is over — is patently false. The federal Liberals never make promises they fail to keep: anyone who has driven over the sturdy all-weather causeway connecting Prince Edward Island to the mainland can attest to that.

Ex-addict permitted to sue BC heroin plan

By Tim Padmore

VANCOUVER — A suit to overturn British Columbia's compulsory heroin treatment legislation now hangs on a middle-aged mother of two from Vancouver's Burnaby suburb.

Brenda Ruth Schneider was granted "standing", or permission to sue, by the BC supreme court in a judgment released Feb 1.

At the same time, the court denied standing to the BC Civil Liberties Association and its president James Dybikowski, the original plaintiffs in the suit.

Mrs Schneider is a former heroin addict, now on methadone maintenance.

Mr Justice Kenneth Fawcus ruled the association cannot sue because its officers and members are under no risk nor will they be directly affected in any way by the provisions of the Heroin Treatment Act.

But Mrs Schneider, because she can be considered "narcotic dependent," is in jeopardy, he said, and can therefore sue.

He rejected the government's argument that Mrs Schneider is unaffected because the Alcohol and Drug Commission has promised she can continue on methadone maintenance provided she does not "abuse" the treatment program.

"The current policy of the Alcohol and Drug Commission may change at any time," he noted.

Mrs Schneider's name was added to the list of plaintiffs at the last minute, after it became evident government lawyers wanted to challenge standing rather than proceed directly to the merits of the suit.

"We have half a win," said Mr Dybikowski after the judgment.

He said no decision has been taken on whether to appeal the decision. The association is not happy with the precedent that has been set denying it standing, but neither does it want to interferc with the progress of Mrs Schneider's claim.

Mrs Schneider has been receiving legal methadone for 10 years. Like others on voluntary methadone maintenance prior to last May 1, she was told she could continue to get methadone provided she does not interrupt her treatment for any reason and does not use heroin, barbiturates, tranquillizers, or other drugs or do anything that interferes with her treatment or the treatment of others.

She said she suspects it's only a matter of time before something happens to disqualify her or ADC policy changes.

Mrs Schneider said she became addicted to heroin when she began using it to "level the downs" that followed use of diet pills.

Californian view of BC plan

It will be 'quasi-voluntary'

By Tim Padmore

VANCOUVER — The voice of experience, addressing the British Columbia heroin plan:

"What you're going to find is that the police and courts are going to push you into a quasi-voluntary program."

The voice belongs to Bob Grove, program administrator at the California drug rehabilitation centre at Corona, Calif.

In an interview with **The Journal** he shared his experiences in 14 years of dealing with a drug problem that dwarfs Canada's. (There are an estimated 50,000 to 250,000 addicts in Los Angeles alone.)

California's drug law is often compared to the new BC plan. Originally the California law provided for committal of people convicted of felonies or misdemeanors, of volunteers and of "involuntary" volunteers who need not have committed any crime. Today, virtually all clients are convicted felons who choose treatment rather than an ordinary prison.

Mr Grove said that at the start there were a number of court cases over involuntary committals but, as it happened, all were settled without the constitutionality of the law being seriously challenged. And when the court cases started to multiply, the involuntary commitals were phased out.

Mr Grove believes that perhaps 50% of addicts can be helped in some way, but he is not enthusiastic about any particular treatment.

"Our philosophy developed over the years to get staff who think they have the solution to the world and let them try to convince the inmates in their dormitory to believe it too. The essentials are that the therapist believes in his treatment and the patient believes in his therapist .... In one dormitory, three-quarters of the women are meditating heavily everyday."

Programs that sound good often have unexpected pitfalls, he said: for example, a vocational program trained inmates in electronics assembly — until the bottom dropped out of the market for assembly technicians.

He said he asks every addict he meets (a total of 15,000 to 20,000 by now) why he fixes. The usual answer: "Because I like it." Only a few feel oppressed and desperately want to get off.

"Addicts to me are people who do things differently and I think the reasons people get upset about them are stupid."

They're smart (average IQ of the women inmates at Corona is 118) and although they may be lacking in some life skills they are very successful in others — particularly the human manipulation necessary to survive and maintain a $1,000 a week habit for months at a time.

The high cost of drugs, he said, does not seem to act as a deterrent.

He recalled that opiate elixirs were freely available just before and after the turn of the century and that addiction was widespread, with four or five times the incidence of today. The addicted then were the lonely and the bored — "there's a whole bunch of those folks around today. If you make a substance available to them how many are going to stumble?

"Of course that same group of people is maybe not the most productive part of society anyway so maybe it wouldn't make any difference."

And a final macabre note: Mr Grove said he has found only eight or nine diabetics among thousands of addicts even though the incidence of the condition in the general population is about 10%. The reason, he believes: the milk sugar most heroin is cut with has snuffed the rest, deaths that in most cases were put down as simple overdoses.

CAF president resigns AFM

WINNIPEG — Lorne Phillips, director of provincial programs for the Alcoholism Foundation of Manitoba, has resigned from his job and will be leaving Manitoba within the next two months.

He said in an interview recently his resignation was for "personal reasons."

Dr Phillips is president of the Canadian Addictions Foundation.

Non smokers win landmark decision

TORONTO — Non smokers here are heralding a decision of the Workmen's Compensation Board as a major victory in their battle against second-hand smoke.

The board awarded compensation to Murdeena Johnson, a 43-year-old non smoker who quit her job in May, 1977 because of health problems she said were caused by smokers. The amount of compensation has not yet been set.

In an article in the *Toronto Star* Mrs Johnson said she quit her job as a clerk and billing supervisor at East York Hydro because of high levels of tobacco smoke and dust in her office where, she said, 50% of her fellow employees smoked. Despite her complaints they refused to stop smoking.

The Non-Smokers's Rights Association, which provided the lawyer for Mrs Johnson, says the decision is a landmark in Canada for non smokers' rights.

The decision demonstrates to employers and employees that second hand tobacco smoke is an occupational hazard to non smokers in the work environment, said Garfield Mahood, executive director of the association.

But Mr Mahood may be overstating the case. In its report, the Workmen's Compensation Board said it accepted Mrs Johnson's appeal "not because of tobacco smoke *per se* but because there was enough evidence ... of unusually high concentration of dust and tobacco smoke consequent upon a restructuring of the ventilation system and failure to recycle the air."

MD residents' impairment neglected

By David Milne

MINNEAPOLIS — A significant problem of impairment exists among resident physicians that is often unnoticed by other doctors, including residency program directors, J. Patrick Tokarz told the 3rd National Conference on The Impaired Physician here.

Underlying the tip of the iceberg of residents who are blatantly impaired is the much larger problem of young doctors who are adopting lifestyles and inappropriate defence mechanisms which will lead to their later impairment in practice, said Dr Tokarz, immediate past chairman of the Resident Physicians Section of the American Medical Association.

Residents play many roles and are often under pressure, he said, which helps contribute to their maladjustment leading to alcohol and drug abuse.

Selection procedures for residents favor the obsessive, compulsive workaholic and the passive-aggressive personality.

These are not, necessarily, the most appropriate personality types to care for patients, nor are they the most stable when faced with the inevitable stress of training and practice, he said.

Because of their many roles, residents have very little time to deal properly with the many demands placed upon them.

Dr Tokarz said the most damaging situation is when a physician in training has unrealistic expectations of himself. The inability to meet these expectations results in the chronic anxiety and depression so frequently found among physicians in training.

There are no accurate figures currently about the scope of the problem of impairment in the residency population. There is, however, increasing evidence residents are unwilling to accept emotional and social impairment as a necessary part of their career.

For each of the last three years, the national meeting of family practice residents has been marked by increasing concern with this problem, he said.

Although there is no adequate data on substance abuse among resident physicians, among medical students 10% drink alone or among a common drinking group, and 14% drink while studying.

Twenty-one per cent are drunk between three and seven times each week, and 10% become drunk every time they drink.

A study done in four geographically separate medical schools revealed 30% of medical students consider themselves current users of marijuana.

Amphetamines are a common drug of abuse among students. One study shows 23% of medical students have used amphetamines more than once, and 15% continue after the clinical years.

The American Academy of Family Practice recently surveyed the 325 family practice residency programs and found more than 70% of the residency programs have identified impaired physicians.

While the majority of programs do have mechanisms to identify and rehabilitate impaired residents, fewer than half of the programs have mechanisms aimed at preventing resident impairment.

The problems encountered most commonly were emotional illness, marital problems, economic problems, drug abuse, and alcoholism — in that order.

Methods to aid the impaired resident all focused on a compassionate approach and concern for protection of the physician's confidentiality and personal dignity.

Most programs have strong teams of resource people available to help the resident suffering from emotional illness.

Many residents with problems of drug abuse and alcoholism were rehabilitated successfully through the supportive efforts of these human resource groups.

The formation of spouses support groups were found helpful in many programs.

One program has established a "Residency Stress" program in which residents and spouses both participate. Another program reports that it conducts periodic workshops for "Couples Communication."

One of the most conspicuous elements to emerge from the survey is the strong influence wielded by the program director in serving as a role model.

Dr Tokarz said the most effective rehabilitative programs are those which identify a support person or committee that will be responsible for coordination of identification of impairment and rehabilitation programs.

Labels tabled on liquor

WASHINGTON — United States Treasury Department officials have turned down for the time being any warning labels on liquor, wine, and beer that drinking during pregnancy could be dangerous to the fetus.

The Treasury made this decision following a split report by a three-member panel.

Geneticist Judith Hall, said there is firm evidence heavy drinking causes the fetal alcohol syndrome, and while there is no firm evidence of the harm of light drinking this still probably causes one to two birth defects per 1,000 births.

Dr Sergion Fabro, department of medicine, George Washington University, declined to make a recommendation. He said heavy drinking may cause central nervous system problems in the fetus. He added that a woman may run serious risk of fetal damage if she drinks three or more ounces of pure alcohol a day.

Amital Etzioni, a sociologist and head of the Center for Policy Research, said more research is needed before the use of warning labels could be justified.

A trip with Marshall McLuhan—

PHOTOS: JUNKO YAMAMOTO

Marshall McLuhan, *the father of modern communications study, has turned his synthetic intellect and wit in recent years to what he calls the "discarnate" or bodiless nature of electronic man. The electronic age makes everyone and every part of the world simultaneous. This erases man's bodily relationship to the physical world, he says. In this special International Year of the Child interview, McLuhan, director of University of Toronto's Centre for Culture and Technology, looks at the relationships of drugs, health, and youth to the discarnate nature of man. McLuhan spoke to writer* **Donald Gregory Bastian** *and* **David Nostbakken**, *national director of education for the Canadian Cancer Society and McLuhan's former teaching assistant. The interview took place in the McLuhans' modest but stately three-storey home in Wychwood Park, Toronto. Second in a series of IYC interviews.*

DGB: You have said that the electronic age has erased borders, or local borders, in a sense. Can you say the same thing about drugs? Have they come about because of a shift in our sense of inner and outer space, that is, our sense of private and social or public life?
MM: Well, drugs tend to be inner trips. On the other hand, there are some drugs that are supposed to be just pain killers, like Muzak. A great deal of our music is really a kind of aspirin. But I think in the radio age, for instance, the big problem was booze. Nobody has ever studied the relation between radio and booze — prohibition.
DGB: How do you make that connection?
MM: It isn't a connection, it's just a relationship. There are no connections in these things, only relationships, which are sort of vibes. The sympathetic vibes between radio and booze were that the radio age created the first, big, mass man, simultaneous man, the Global Village.

The telegraph had done a good deal in that direction, but radio was a very obvious and new dimension of this simultaneity. Every part of the world became simultaneous, instantaneously present. To that extent, radio was a kind of inner trip, a kind of fantasy world.

Not nearly as much as television. But the radio age specially stepped up the sensitivity of the ears, ear experience. And the tribal man, who lives acoustically, who relates to his fellows mainly by ear, has never been able to drink booze. It's too potent for him. It heightens his relationships to his fellows to a degree that is intolerable. He doesn't need any incentive in that direction. Whereas the visual man, the literate man is, as we say, a gentleman who knows how to carry his liquor. A literate man needs quite a lot of booze just to be human.

Inner tripping

DGB: To break himself up.
MM: To relate to people. He stands back from people. The Indians, the Arabs, and so on are all teetotalers, for the simple reason they can't stand booze.
DGB: They're already loosened up enough?
MM: They're already acoustically related. So, when radio came in it broke down the sort of spaces between literate men to a point that frightened the establishment. They didn't know, they were completely unaware of the causes of their action in prohibition. Because booze was not a new thing. What was new was radio. Booze had been around in large quantities all through the American history. But radio had not.

That raises another question. How much individuality remains at the speed of light? The radio age is the first mass age. The phrase came in — mass culture. Nobody ever spoke of the printed world as mass culture. It doesn't matter how many books are sold, they never thought it was a mass, because it was strongly related to private, individual reading. But radio certainly is a mass phenomenon. Take the famous Orson Welles broadcast. The fantasy world becomes just as real as the real world, you see, with radio.

DGB: How would you describe the addictive properties of the media?
MM: I think the addictive properties are *mimesis*, that is to say when people went on their first real inner trip with television, they wanted to repeat that in another medium, to reinforce it. Real inner tripping came with television. I don't know if you could say it was an escape from self or from inner-outer in the sense I was talking about, because I think one of the first facts of television, one of the first facts of the electronic experience, is loss of identity. Private identity is pretty well wiped out even when you're on the telephone. You see, on the telephone too, you are on a peculiar trip, you have no physical body.
DGB: You're in two places at once.
MM: Well, you're nowhere, in a sense, because you aren't anybody, you lose your identity when you go on the telephone. And you lose your relations to natural law, you lose your identity, your sense of yourself. That's why the obscene telephone callers have become sort of a monumental problem. People suddenly feel irresponsible on the telephone.
DGB: They can do anything they want.
MM: No way of checking on them. The inner tripping goes along with loss of identity.
DN: And dropping out.
MM: And dropping out.
DGB: Do you see the 60s drug movement as a backlash against the loss of self through the media?
MM: When you lose self, the first phenomenon is violence. The first kickback from loss of identity is violence, panic. They want to find out who they are and they get tough and violent as a way of discovering "Who am I?" It's a way of accentuating.
DGB: It happens to cultures that are devastated by another culture.
MM: Invaded by other cultures. Literally, when you're on a border, you develop a sort of violent or hostile attitude. It's not neutral, borders never are. They're places where the action is. There are many borders, psychic borders, in our world. But there's this huge loss of identity which drives people nostalgically to looking for something real. Something they were once sure of. And by the way, at the speed of light, you're not going anywhere. You don't have any more goals or directions. You're already there. So this is one of the big factors, loss of goals, loss of identity.
DN: What were they sure of in the 60s that they were getting back to?
MM: Well, they were granddaddy's overalls, what we call jeans. Granddad was real. He had a beard, and he had overalls, work trousers. He had a relation to roots, ground. The ground you stand on, all that. Nostalgia took many, many forms, but the nostalgia for earthy things became a very noticed feature.
DGB: But what about drugs? Some of those same counter culture types still stayed on speed or marijuana, or just any kind of drugs.
MM: But this is a form of violence. All drugs are violent, because they are ways of probing and trying to discover who you are. These trips are quests for identity. And you discover you're all sorts of people. So the quest for identity is a violent thing, it is very much a part of the drug trip. People who have lost their identity are violently seeking to discover, "Who am I?"
DGB: Maybe even something like a cigarette helps you, when you're outside, to be with yourself, secure.
DN: Well, a cigarette is like a break. Like a coffee break.
MM: Well, this is a very big feature of going outside to be alone, because the coffee break was an interruption of the whole work habit. In our old society, a man who went to the office didn't go to socialize, he went to be alone. But the coffee break was an interruption of that event.
DGB: It brings you back into the public.
MM: People were very conscious of socializing with a cup of coffee. Now they take it for granted, but 15 years ago it was revolutionary.
DN: The interesting thing about three or four pack-a-day smokers is that they're getting a break all day long.
MM: Relaxing on company time.
DN; It's like drinking coffee all day long. When you're having a cup of coffee, you're not really working. You're only half there.
DGB: What terms would you put on any one person who is smoking pot? What is he doing?
MM: I would say mainly he's being naughty. He's an alien, or a rebel.
DGB: So really there's not that much difference, in this sense, between smoking a cigarette and smoking pot. It all has the same social function.
MM: I don't know if it's the same, but it is easily related.
DN: It is a social function, too. Young kids are smoking not only for themselves but to impress the larger group.

Psychic barriers

MM: If it were all permitted, it would change the attitude, if there were no legal restrictions.
DGB: There's a big social push now against cigarette smoking, and at the same time the government is considering decriminalizing marijuana smoking. Now, I guess because we discovered second-hand smoke may hurt us, we get disciplined with tobacco, but we haven't found what marijuana is going to do yet, so we don't say anything about it.
DN: In terms of what it does to you physically, you don't smoke 80 joints of marijuana a day, whereas you may smoke 80 cigarettes. There's quite a difference. It could be that the mass media, particularly the television film, where smoking is so commonplace, has made it so accessible it's less desirable.
MM: Cigarette smoking came in the 20s and it was very much a part of the radio age. Of course, women did not smoke, except the very naughty ones.
DN: But now you're not being rebellious to smoke, and it has become less interesting.
MM: But these psychic barriers have always had their roots in something else so that this hidden factor of going outside to be alone has never been spotted by sociologists, and yet it affects all of our lives, all the time — choice of work, everything — and now has switched because in the TV age we have flipped from going out to be alone, to the exact opposite. You go out to be social, to play roles.

The job hierarchy chart does not exist at the speed of light or television speed. It folds, it's like a collapsible Christmas tree. The chart has folded and when the exec drops out, the pressure is on him not to hold a job. You see, the chart is based on job holding and slots. The slots, though, get all rubbed out, like a glissando in music. The slots get pushed out, but he then has to become part of a group, and he has to play roles. So the exec has flipped from job holding to role playing, and he's still having one heck of a time making this transition. It's really a very crucial and miserable period that we're going through in that department and part of it is Women's Lib.
DGB: How is that related?
MM: Totally related, not partly. In women, we have a being long conditioned to role playing. They have a huge advantage over men in the new electronic time.
DGB: Because they know how to fit in?
MM: No, it's not fitting in. That's the old exec chart, that's the job chart. They don't fit in. You have to take on multiple functions. As a role player, you don't have a job, you have many jobs. A role can be many jobs. If you're an actor or a role player, you're not limited to just one part. You don't have to play Hamlet all the time, you could play the ghost in *Macbeth*.
DGB: Has that come from television, from seeing roles or images on TV?
MM: No, I think it's a loss of identity. The male ego tends to be more fragmented, specialist, and therefore role playing is harder for him. The role player tends to have a fairly flexible attitude to himself. Our North American males have tended to be pretty angular, prickly, non-adaptive — and proud of it. Now they suddenly are threatened with the need for adaptation and flexibility. Diversity and flexiblity are other names for involvement.
DN: In the health field, the idea of nostalgia is very important.
MM: Well, look here, to prove that you have a body in a discarnate time, jogging is just one way of proving that you're still real.
DN: It's even gone beyond proving you're real, it's really a very narcissistic thing, almost a hero worship of your own body.
MM: Narcissism is one point at which you achieve identity. But it's only a very tangential, immature part of the identity process. And so, I don't think that narcissism would be a very good indication of real identity for anybody.

On the other hand, what about charisma? Charisma is part of the television problem, because it

through drugs and TV to Jonestown

means not a private but a group identity. It means looking a lot like a lot of other people. If a person has charisma, he is so highly representative of a solid group of people, which gives him identity.

DGB: It makes him a leader of the group, too.

MM: Not necessarily a leader, but he gets acceptance by looking like other people. You don't have to go any farther than (Walter) Cronkite. There's no private identity at all.

The drug village

DGB: What about other media and drugs?

MM: Print, too, is a very heavy drug. People who have been deprived of it get terribly panicky. People who have been in prison camps have talked about how, whenever they did manage to get just a few lines of printed words, it was passed around the whole camp, just for the sake of being able to see some words. It would be like a precious bit of food.

I think a lot of our feeling about the news has some of that quality. You know, you put your head in a newspaper and you feel at home.

DN: And you don't necessarily have to get anything substantive from it.

MM: Oh, no, no. It's just like getting into a tub of water, that's all. You dip yourself in the news. And you don't intend to carry it with you during the day any more than you care to take your water beads from a shower.

The drug craze, or any kind of craze, is a put on. It's a way of relating to other people. After all, the need to hold any kind of special show or entertaining content of any sort is mainly determined by the other people around you. It isn't the individual who decides on the need for something to be current or popular. On the other hand, the people who are always searching for clues, once they do hit upon them (and they don't really know how to find them) just do it again and again. If something is a success, you have Jaws II or III, you just get everything repeated, repeated.

DGB: About the global village, about what you call simultaneity — electronics have made that possible, but what about drugs? There's no longer really a border between the Third World and First World, in the sense that the peasant in Thailand is supplying someone on the streets of Toronto with opium, indirectly.

MM: The electronic world is Third World. You must also remember the motorcycle cult, based on Robert Pirsig's *Zen and the Art of Motorcycle Maintenance*. This is all a drive toward the East. The drive toward the East is in every phase of our culture. Orientalizing is also a move toward a world where there is no identity, there's no private identity, there's only group identity. In Japan, now, they've made a big drive to the West, taking on our industrial technology.

DGB: And alcoholism is higher there now.

MM: But this drive alienated them from themselves and their culture, and they're in a terrible state of self-crucifixion. They have a big alcohol problem? So do the Scandinavian cultures, on a scale we don't even hear of happening here.

DN: You were saying before that you thought the prohibition was related to radio.

MM: Again, as a kind of time lapse, a kind of harmonizing. No connections. Anyone looking for connections is an entirely left hemisphere person, looking for ways of nailing it down.

DN: In the health field, that's how we tend to treat problems of health. We are looking for cause and effect relationships all the time. And not for over-all patterns.

MM: My friend Ross Hall says that's why they don't have nutrition studies in medical schools. Because the doctors are looking for causal reasons why they should put nutrition in medical schools. They argue that no one has ever proven that there's any relation between health and food.

DN: The cure for scurvy was being used by the British about two centuries before it was accepted in the scientific community.

MM: The medical schools are even now very hesitant about adding nutrition studies. I think they're tending a little bit in that way, but they're not convinced.

DN: Medicine is based on a scientific method of inquiry.

MM: Meaning one disease, one cause, and one cure. There's one cause and one cure for every disease in the scientific mind.

DN: Or, in the field of cancer, for example, they don't talk about one cause of cancer, they talk about many cancers with many causes.

MM: Well, now they've finally called it a way of life.

DGB: Life is carcinogenic.

MM: It's very significant that John Wayne should come up as a very heavy cancer case, because he manifests our whole way of life at every level, even at the cancer level. He has cancer through and through and he's still kicking.

DGB: You speak of the media as drugs, but speaking of the physical substances of drugs themselves, have they provided another global network, in that the Third World is providing us with our recreation?

MM: Transcendental Meditation is another drug that is imported from the East. I was wondering, what had been some of the uses of drugs in other cultures, like the oriental ones?

DGB: They were generally more religious and ceremonial.

MM: They weren't for indulgence.

DGB: No, not as much.

MM: That would be a pretty good place to ascertain the contemporary drug problem, finding out the variety of uses that have been put to it long before us. Laudanum was a sort of aspirin used all through the nineteenth century. You could pick it up at any pharmacist. Pharmacy, by the way, is a word for poison, so the old idea of a pharmacy was a place where you want to get rat poison or anything.

Nostbakken:

'Jogging is almost a hero worship of your own body.'

DN: The drug culture as we know it is usually associated with youth; and youth is an electronic medium invention.

MM: The network television arrived in 1948, so the first TV generation — completely brought up on TV — was 1960. So what happened? After 10 years of strange manifestations, they seem suddenly to have quieted down.

DN: But that's when youth began, too.

MM: No, youth cults were quite strong in the 20s. There was a book called *The Doom of Youth*, which analyzed the roots of the youth cult and pointed out that as soon as you begin to play up the value of anything, it's doomed. If you started to glorify old age, for any reason at all, it's doomed.

DGB: Do you think if you decriminalize marijuana, that it is doomed, eventually, to the fate smoking is experiencing now?

MM: I'm not sure about marijuana, I'm just not sure. But any kind of isolation of a factor tends to make it vulnerable. The youth cults of the 20s were tremendous, they were a glorification of youth by older people.

Alienation

DN: But I'm talking about the activistic youth of the past few decades. They glorify themselves, and they're very narcissistic.

MM: Well, that's obviously not very long for this world. It's a TV phenomenon.

DGB: In the addictions field, there are those who say the way to deal with the harder drugs is to get them at their source. But there are others who are saying there is something similar about taking Valium and taking cocaine or taking any drug. They're focusing on the consumer side of the problem. Does this have any relationship to what you call the Global Village?

MM: Well, one of the things that has always puzzled me is when people say to me that this village I talk about is utopia. But if you know anything about villages, you know that members of a village tend to dislike each other very much. They know too much about each other. Well, that's our condition today, with our espionage systems, our fantastic inventions, our data banks. We know too much about each other. We can't stand to live with each other anymore.

DN: And we're probably more like each other too. Most of us in Canada spend at least three hours out of every day watching television.

MM: Now that is a drug trip, that's the main drug trip. It is an alienating experience. You wouldn't call watching television doing something. Something's being done to you, it's like going to a sauna bath. It's the exact opposite of doing something. The time when you could say we are all doing the same thing, nine to five, every day, that disappeared, I'd say, 20 to 30 years ago. We have moved more and more into a role playing culture. You never know what the guy beside you is doing. He may be a CIA agent, you don't know. He could be a very big guy in some other league, but you don't know. This kind of anonymity is part of our simultaneity. When you're simultaneous, you know very little about the guy right beside you. You just have shadows.

DGB: How are drugs a technology?

MM: I have a simple approach to all technologies — any manmade thing, a word, or anything. I ask four questions: what does it enhance? what does it obsolesce? what does it retrieve? and what does it flip in to, if pushed far enough? What does a drug enhance? It is a sudden release from some particular aspect of experience. It enhances freedom. I remember once getting a shot of morphine when I had a kidney stone and what a release that was. Suddenly no pain at all.

The second aspect of any manmade thing is obsolescence. Drugs obsolesce this miserable, cramped, repressed condition. Any manmade thing retrieves something that had been pushed out earlier, maybe much earlier. There's a huge retrieval in every aspect of innovation.

McLuhan:

'We'll get so sick of youth we'll phase it out.'

DGB: Do drugs retrieve a sense of infantile experience?

MM: It could be a sort of retrieval of a feeling of freedom as in your first world. Drugs releive you of a need for syntax and rational expression. You suddenly are liberated from all that. So you could say drugs provide a retrieval of a primal state where I'm as free as a bird. You flip out of visual space with drugs into a more acoustic space which is more musical, more beautiful. And any technology, any kind of manmade experience pushed to its limits, flips into its opposite form.

Death for thrills

DGB: How has that happened with drugs?

MM: Well, it becomes a habit. You're trapped. You're caught. Instead of being as free as a bird, you're a bird in a cage.

DN: Or it's a medicine.

MM: Well then it becomes a must.

DN: You're compelled to take it. It's a much more systematic thing than drug addiction.

MM: However, the addiction is itself a trap — you're hooked. So you push the drug. It's delightful, delightful to you and suddenly — wham, it's a downer.

DGB: What about the relationship between youth now and drugs and cults? Some of those cults will take people who have been on drugs and replace the drug experience with communal experience. Have they pushed the drug to retrieval?

MM: When you get to the trap side, then a new four-part thing takes over. What does the trap enhance? It enhances awareness of the fact that you are trapped. What does it obsolesce, and so on, until, pushed all the way, it becomes freedom, you fight your way back.

DGB: You say TV is an inner trip, and that the generation that arrived fully grown on TV was the 60s generation. Do you think the drug push was a way of enhancing that television fantasy?

MM: I'm not sure. Remember, on TV, on the air, you're discarnate. And loss of identity goes along with that response. But the activist violence itself tends to be a kind of fantasy and so is terrorism. The terrorists have pushed the activist response to another dimension. The Baader-Meinhofts and the Red Brigades are upper middle class people who are deprived of their usual outlets in life. They have everything, there's no place to go, there's nothing they want in the world, they've lost their ability to experience. And so they have become engaged in a kind of ultimate fantasy, in which you destroy your own life, just for a thrill.

DGB: What about destroying yourself through drugs?

MM: I don't imagine that's deliberately programmed, it's not part of the original intention.

DN: It may be the same kind of adolescent response to the situation you described. Like a small child kicking the can.

MM: The way you achieve identity is finding your personal limits and if you find your limits by banging your body and head against things, or trying your talents on this or that, you're finding your limits.

DN: And the upper middle class, well-educated person has a much wider breadth in which to kick.

MM: His limits have become a very heavy weight on him. He's bored. So the drug trap is also boredom.

DGB: We've talked a lot about the past, but what do you see for the future, for youth in the future?

MM: By youth you mean a state of mind.

DGB: The Year of the Child takes you up to say, 18 years.

MM: Well, that's going a long way. I think those limits are unreal. We talk about continuing education — we've finally realized education doesn't have to stop. We don't consider childhood as a limit any more, or working years as a limit. The Year of the Child, I suppose, is a kind of playing with the well known soft-heartedness of Americans toward babies — little helpless things.

DN: As you mentioned before, if you highlight things, it's a way of getting rid of it. International Women's Year was a way of dealing with Women's Liberation. Have a year, and then you don't have to worry about it anymore.

MM: Just drop it, yes.

DN: This is our way of just dropping kids.

Identity lost

MM: Specialization is a dangerous thing. We'll get so sick of youth, we'll phase it out. Electronic man doesn't have any controls. He's not going anywhere. It's the (John) Travolta thing. You just have a role to play. And a role player in this sense just is playing make believe.

DGB: When a person's fantasy of television becomes his reality, do we have something analogous to the person who uses drugs to the point where they become everything he must have?

MM: That is his only reality. That's the Guyanese (Jonestown) thing. The Guyanese thing is the ultimate of pushing the TV experience.

DGB: How so?

MM: That in itself is a horrible literalness — pushing the TV experience all the way. Those people were all Americans, they grew up in the San Francisco area, they had undergone the TV generation experience completely. They lost their identity, tried to recover it through a group. When you've lost your identity that completely, death doesn't mean anything. That's why this big interest in life after death now, the people who come back and supposedly talk about what's beyond death.

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If dependence isn't psychological, what is it?

W. A. McKim (**The Journal**, Jan) objects to my use of the term "drug dependence" on the grounds that it is inappropriate, "archaic and misleading jargon", because it implies that "drug seeking behavior is in some way different from any other pleasure seeking or goal directed behavior". I regret that he has missed the point of my letter, which was precisely the same as the one he makes. Indeed, the principles of stimulus and schedule control of reinforced behavior do apply equally to drug-taking, eating, gambling, and a variety of other behaviors, as he argues. These principles are the essence of psychological dependence, which I was contrasting with the abstinence syndrome ("physical dependence") that can be produced by passive exposure to drugs.

Unfortunately, in rejecting the term "psychological dependence," Dr McKim offers no alternative that the public can use, unless by implication he wishes to substitute "drug seeking behavior".

This alternative is totally inadequate because it entirely misses the point of compulsion or, as in current psychological jargon, strongly stimulus and schedule controlled behavior. Drug seeking, with no further qualifications, encompasses all sorts of behaviors from taking an aspirin tablet for relief of a headache to drinking a glass of champagne at a party. Obviously these acts do not qualify as drug dependence or, even better, as drug addiction. I grant that the distinction between casual or infrequent drug taking and what we presently call drug dependence is difficult to make. The by now well recognized principle of the unimodal distribution of alcohol consumption illustrates the problem most aptly. But the fact remains that most of us can recognize the difference between a drinker and an alcoholic.

Despite the efforts of the World Health Organization Committee on Dependence Producing Drugs to arrive at uniform terminology, reflecting the similarity of the consequences of chronic drug self-administration, the present usage is utterly chaotic. Even though the underlying behavior phenomena may be the same, everybody from the most sophisticated experts to the lay public refers to "heroin addicts," "alcoholics," amphetamine or cocaine "abusers," etc. There is no consistency. This I find regrettable because it reflects more the current and often ill-founded value judgments attached to these conditions, than the present scientific understanding of what is common among them.

In my view, addiction is still the best term, as long as it is not equated with physical dependence. During the 19th and part of the 20th centuries it was used uniformly to refer to the compulsive chronic use of opiates, alcohol, cocaine, hashish, etc. But during the 1950s and 60s the WHO Expert Committee made heroic efforts to distinguish between addiction and habituation, and the troubles that usually accompany strenuous efforts at precise definitions began. In fact, Dr Nathan B. Eddy, a distinguished member of the Committee, said publicly in 1965: "The World Health Organization drew up definitions of addiction and habituation some twelve years ago, and modified them some five years later. These definitions were more or less accepted, but really we wish now that we had never written them". So do I.

Secondly, I am essentially in agreement with Dr McKim's statement that "chronic administration of an effective dosage of any drug will produce a physiological change when it is discontinued" ie physical dependence. But I do not agree with him that the distinction between "physical" and "psychological" dependence is only a quantitative one. There are indeed quantitative differences in the severity of withdrawal symptoms produced by drugs with essentially the same actions, or by different levels of use of the same drug. But the withdrawal syndrome following discontinuation of amphetamines and cocaine is qualitatively different from the one that ensues on withdrawal of depressants. In fact, they are like mirror images, ie in the former the symptoms resemble those produced by the administration of depressants, and in the latter they resemble those produced by taking central nervous system stimulants. Yet the behavioral principles governing the self-administration of these drugs ("psychological dependence") are identical, despite qualitative differences in their pharmacological actions.

The main point of my original letter was that these concepts are not generally accepted, even by many workers in the field. The fear of, and attribution of major importance to physical dependence persist and strongly influence expert and public opinion, including the scheduling of drugs for legal purposes and the empirical application of the law. This problem would disappear if the word "addiction" were rehabilitated and its original, purely descriptive meaning were reinstated. Mechanistic, as opposed to descriptive, terms are more transitory because concepts change. Also, they can be very cumbersome.

For example, the name of our institution — *The Addiction Research Foundation of Ontario (ARF)* — is both appropriate and apt. Archaic or not, it is surely far better than *The Strongly Stimulus and Schedule Controlled Drug Seeking and Self-Administration Behavior Research Foundation* or, *in short, SSSCDSSABRF.*

Oriana J. Kalant, PhD
Scientist
Addiction Research Foundation of Ontario

English to 'depend' on

I beg to differ with Dr W. A. McKim's comment (**The Journal**, Jan) that "the term 'dependence' should be eliminated since it implies that drug seeking behavior is in some way different from any other pleasure seeking or goal directed behavior."

Just the opposite is true. The term 'dependence' should be kept because it is a perfectly valid English word — simple, well-known, generally understood — which can be, and is, used, to describe *any* kind of behavior involving continual reliance upon someone or something for a given purpose. Hence the implication that drug seeking behavior is essentially similar to, and not different from, other forms of pleasure seeking activity.

Dr McKim's letter reminds me of a certain psychology textbook I once saw in which the 'archaic' term 'sentence' was replaced by the more 'modern' term 'linguistic event'. In my opinion, both the beauty of the English language and the cause of communication are threatened by these needless attempts at modernization.

Lise Anglin
Documentalist I
Research Planning
Addiction Research Foundation of Ontario

Thank you staff

I enjoyed "meeting" all of The Journal staff in the Year End Review (The Journal, Dec, 1978).

Thank you for the impressive recognition you have given the International Year of the Child in recent issues.

Marian B.S. Crymes
Washington Correspondent
Women's Christian Temperance Union

Canada formalizes alcohol and drug training

By Karin Pargas

'A national priority'

TORONTO — A formal training system is a national priority for workers in the alcohol and drug dependence field in Canada.

This is the opinion of a team of people who have spent almost five years investigating and implementing a systematic approach to training.

So far, there have been two tangible results of the team's concerns: a national project involving the training of 21 key people in Canada, so they may, in turn, train other trainers; and the publication of a 12-booklet package: *Core Knowledge in the Drug Field: A Basic Manual for Trainers.* It is written largely by Canadians.

Chuck Simmons, then with the Non Medical Use of Drugs Directorate, department of national health and welfare, was a principal investigator in a survey of training needs in Canada.

Two major issues

The survey was begun in 1974 when senior people in addiction services were interviewed to determine training strategies and needs within their own jurisdictions. Although there were particular needs and priorities, there was also a general feeling that the potential for collaborative efforts nationwide should be explored.

Mr Simmons: "Back in the late 1960s and 70s, there were a few ways in which people were able to get some kind of knowledge or skill input. Primarily, these were through various summer schools, the annual Canadian Addictions Foundation conference, staff development programs, and the occasional consultation with an expert outside their own jurisdictions."

Following the survey of training needs, the Federal-Provincial Working Group on Alcohol Problems (now the Sub-Committee on Alcohol and Other Drug Problems) established a task force which assigned priority to two major issues:

- the unevenness of basic knowledge about alcohol and other drug dependence, and associated issues held by workers in the field, and;
- the need to ensure that the knowledge and skills of training staff were at a high level.

In 1976 the task force became the National Planning Committee on Training for Alcohol and Drug Services (NPC).

Essentially, the priorities set the wheels in motion for 21 key people in the field to be brought together to become part of a Training of Trainers demonstration project. Meanwhile, another sub-committee began to solicit manuscripts for a core knowledge manual.

Donald Meeks, chairman of the sub-committee on Training of Trainers told **The Journal** the objective of the demonstration project was to "improve the quality of knowledge and skills of training personnel in Canada, as one of the vehicles toward moving to development of other training programs ..... The overall objective of Training of Trainers was to produce a cadre of highly trained, knowledgeable trainers so they could, in turn, use their knowledge and skills to train other trainers within jurisdictions, or across jurisdictions."

The logistics of the demonstration project, managed by Mr Simmons, involved seven training sessions for the participants in cities across Canada over a 19-month period, ending in January.

According to one status report, "various geographic locations were selected for training so the participants in the program could interact directly with colleagues in different parts of the country, thereby developing first-hand impressions of the uniqueness of the various jurisdictions."

Participants received training in adult education theory and practices; the design and delivery of short term and complex training programs; communication theory and practices as they relate to training; training in the organizational context; and specialized training needs. Participant task groups studied training of paraprofessionals, training at the jurisdictional level, primary prevention and school education training, staff development and administration, and training in a community context.

Dr Meeks, director of the Addiction Research Foundation of Ontario's School for Addiction Studies said the *Core Knowledge* manual is already in use.

Mandatory instruction

"I think one of the beauties of *Core Knowledge* is that it lends itself, in a flexible way, to support basic knowledge courses wherever they're conducted. In the School for Addiction Studies, for example, we would have had some kind of basic knowledge program in any case, but what we have with *Core Knowledge* is a good baseline of information."

Already, two provinces, Manitoba and Ontario, have developed programs which provide instructions on basic knowledge to staff (and, occasionally, to people outside the provinces).

Alcoholism Foundation of Manitoba staff have also used *Core Knowledge*. In most instances, it was mandatory that staff take instruction via the manual and "pass" with a 60% grade, according to Lorne Phillips, chairperson of the *Core Knowledge* task force, and recently-resigned director of provincial programs for the AFM.

Dr Phillips: "Not only did they (AFM staff) learn a lot about basic concepts and ideas in the field, they learned a lot about the field in general, about the magnitude of the field."

Where does the National Training System go from here?

According to Lavada Pinder, chairperson of the NPC (and also director of the Program Resources Division, Promotion and Prevention Directorate, department of health and welfare, further development is based on the following principles:

- a general strategy shift from demonstration at the national level to jurisdictional and inter-jurisdictional levels, and;
- a reliance on *Core Knowledge* and Training of Trainers programs and products in the design and implementation of these programs.

A recent NPC report to the Sub-Committee on Alcohol and Other Drug Problems states: "The development of a National Training System is necessary and feasible; the national priorities on which major projects are based are still significant; the next phase in development should build systematically on existing achievements and, in so doing, logical steps will be taken toward full implementation of the NTS."

The committee's recommendations, approved in Nov, 1978, to ensure the future of the National Training System, are explicit:

- that the NPC undertake a planning strategy: to identify jurisdictional and inter-jurisdictional needs for basic knowledge and training; to identify resources to meet these needs; and to develop responses matching needs with resources, establishing priorities, and defining geographical areas for implementation;
- following this assessment, that the NPC identify inter-jurisdictional programs for approval by jurisdictions involved;
- that the NPC develop an information bank as a structure to support effective use of the resources located within the jurisdiction. It should include an inventory of expert consultants, resource materials, program models, and other information specifically related to basic knoweldge and training of trainers programs;
- that the federal, provincial, and territorial member agencies of the NPC agree in principle to contribute resources in the form of expertise and program materials for the implementation of basic knowledge/training of trainers programs, and;
- that the Promotion and Prevention Directorate agree in principle to contribute sufficient human and financial resources to assist in the implementation of these activities.

The Ad Hoc Committee's report concludes: "Without continued attention to national priorities, without mutual support across jurisdictions, and without a systematic approach, little of consequence can happen in our field for Canada as a whole."

The Journal welcomes Letters to the Editor. Letters, bearing the full name and address of sender, may be sent to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

GILBERT

'More and more, drug abuse is being condemned not because it is immoral or unhealthy, but because it is uneconomic . . .'

By Richard Gilbert

Costs and benefits of drug abuse

Estimating the economic costs of drug abuse is becoming fashionable. Successful grant applications now include smart references to the cost-reducing nature of the likely results of proposed studies. Even poor grantsmanship pays passing homage to the huge costs of excess. Government policymakers are becoming mesmerized by speculation about the relation between lifestyle and the Gross National Product.

More and more, drug abuse is being condemned not because it is immoral or unhealthy, but because it is uneconomic.

Does drug abuse provide net economic costs to society? It is hard to say. Almost no one has attempted to estimate the economic benefits of abuse. Ponderous papers about "the economic consequences of drug abuse" deal exclusively with costs. Yet even a superficial analysis suggests that, in strict economic terms, costs and benefits may be pretty similar.

The principal economic benefit to society from drug abuse arises from the fact that abusers die young and, consequently, need less support in their retirement years. Take smoking as an example: a simple calculation based on reasonable assumptions allows the conclusion that there were 230,000 fewer Canadian senior citizens alive in 1976 than there would have been if the cigarette had never been invented. Had they been alive these senior citizens would have consumed services and resources to the value of some $1.6 billion. Thus this factor alone represents an economic benefit of smoking amounting to twice a recent estimate of the economic costs of smoking made for Health and Welfare Canada, and a little over half a recent United States estimate of costs adjusted for Canadian particulars.

Does this mean that we should start encouraging smoking again so as to relieve governments of the burden of escalating costs of geriatric care? Certainly not. What a proper analysis of economic costs and benefit might do is little more than remind us that people who see life in purely economic terms are probably suffering from a lack of moral education.

We should not be concerned about drug abuse just because it depletes or adds to the Gross National Product. If we are worried about drug abuse, it should be because of our compassion for suffering individuals and our concern for the deterioration of society.

If we focus on important rather than spurious reasons for concern about drug abuse, we might start asking such interesting questions as: do drug abusers really suffer? and, is our society really deteriorating because of excessive drug use? Economic justification for studying or fighting drug abuse may be no more than a clever way of avoiding hard questions about ourselves and our society.

A proper analysis of economic costs and benefits might also lighten the burden of guilt that is being laid on smokers and heavy drinkers. They are not necessarily costing society a packet, or hogging more than their share of treatment facilities. Indeed, if overpopulation and unchecked exploitation of non-renewable resources are truly the major problems of our age, those who choose to depart prematurely may be doing society a favor.

Moreover, such a bold statement of the benefits of drug abuse may do more to encourage sobriety among those hastening themselves to an early grave than any amount of preaching about the costs of abuse.

Next month: Public and private drinking.

SMOKING:

This description of cigarette smoking by Joseph Califano, United States Secretary, department of Health, Education and Welfare, is now reinforced dramatically in the second US Surgeon General's report on Smoking and Health, a 1,200 page exhaustive survey of 30,000 entries in the world literature by experts. It not only confirms original conclusions drawn in 1962 by the Royal College of Physicians and Royal College of Surgeons, London, and in 1964 by the US Surgeon General, but, in the words of Mr Califano, "reveals with dramatic clarity that cigarette smoking is even more dangerous — indeed, far more dangerous — than was supposed in 1964." This is an edited summary of the conclusions on the health consequences of cigarette smoking.

Mortality

- The overall mortality ratio for all current cigarette smokers, irrespective of quantity, is about 1.7 (70% excess) compared to non smokers.
- Mortality ratios increase with amount smoked. The two pack a day smoker has a mortality ratio of 2.0 compared to non smokers.
- Overall mortality ratios are directly proportional to the duration of cigarette smoking. The longer one smokes, the greater the risk of dying.
- Overall mortality ratios are higher for those who initiated their cigarette smoking at younger ages compared to those who began smoking later.
- Overall mortality ratios are higher among cigarette smokers who inhale than among those who do not.
- Although mortality ratios for smokers are highest at the younger ages and decline with increasing age, the actual number of excess deaths attributable to cigarette smoking increases with the age.
- Former cigarette smokers experience declining overall mortality ratios as the years of discontinuance increase. After 15 years of cessation, mortality ratios for former cigarette smokers are similar to those who never smoked. Although mortality ratios for any given age for former smokers are directly proportional to the amount smoked before cessation, and inversely related to the age of smoking initiation, cessation of smoking does diminish such individuals' risk regardless of these former factors, provided they are not ill at time of cessation. (Actually, the mortality ratios among those who had discontinued smoking less than one year before enrollment in several of the prospective studies were higher than for current cigarette smokers. This was also manifest in the total mortality rates for former cigar and pipe smokers. Further analyses separating those who stopped smoking because of illness from those ex-smokers who stopped for other reasons revealed higher mortality rates among the former.)

A number of new findings in the relationship between smoking and overall mortality were found over the 15-year interval:

- Calculations from prospective study data have indicated that life expectancy at any given age is significantly shortened by cigarette smoking. For example, a 30 to 35-year-old, two pack a day smoker has a life expectancy eight to nine years shorter than a non smoker of the same age.
- Overall mortality ratios increase with the "tar" and nicotine content of the cigarette. For smokers of low "tar" and nicotine cigarettes (less than 1.2 mg nicotine and less than 17.6 mg "tar") overall mortality ratios are 50% greater than for non-smokers, and 15% to 20% less than for smokers of all cigarettes.
- For the 1964 report, data were inadequate for firm judgments on the mortality status of female cigarette smokers. Adequate follow-up in the prospective studies during these past 15 years has revealed mortality ratios for female cigarette smokers somewhat less than those for male smokers. This difference is deemed to be due to differences in exposure (later age of initiation, fewer cigarettes per day and use of cigarettes with lower "tar" and nicotine content). Their dose-responses (quantity, age at initiation, duration of smoking, inhalation, "tar" and nicotine content) are the same as for male cigarette smokers. Subsets of females with smoking characteristics similar to those of men experience mortality rates similar to those of male smokers.
- From the detailed data of two prospective studies the excess in mortality is noted to be greatest for the 45 to 54 year age groups among men and women. Thus, smoking mortality is premature mortality.
- Although mortality ratios are particularly high among cigarette smokers for such diseases as lung cancer, chronic obstructive lung disease, and cancer of the larynx, coronary heart disease is the chief contributor to the excess mortality among cigarette smokers.
- Lung cancer and chronic obstructive lung disease, in that order, follow after coronary heart disease in accounting for the excess mortality.

Morbidity

- In general, male and female current cigarette smokers tend to report more acute and chronic conditions, such as chronic bronchitis and/or emphysema, chronic sinusitis, peptic ulcer disease, and arteriosclerotic heart disease, than people who never smoked.
- A dose-response gradient was noted with the amount of cigarettes smoked per day for most of the chronic conditions. Particularly impressive is the gradient for chronic bronchitis and/or emphysema, with an increase in prevalence among male smokers of two packs or more a day to four times that of those who have never smoked.
- The age adjusted incidence of acute conditions (eg, influenza) for males who had ever smoked was 14% higher, and for females 21% higher, than for those who had never smoked cigarettes.
- Indicators of morbidity which are not dependent upon physicians' diagnoses include measures of disability such as work days lost, days in bed, and limitation of activity resulting from chronic diseases:

(a) *Male current smokers of cigarettes reported a 33% excess, and female current smokers a 45% excess, of work days lost in comparison to people who never smoked. Male former smokers had an excess of 41%, and female former smokers an excess of 43%, of work days lost. From the 1974 survey data, this calculates to more than 81,000,000 excess days of work lost for the US population in one year.*

(b) *Male current smokers had a 14% excess, and females a 17% excess, of days of bed disability over those who never smoked. Smokers in all age and sex groups, except for women over age 65, reported more days in bed due to illnesses than did people who never smoked. From 1974 data, this calculates to more than 145,000,000 excess days of bed disability for the US population in one year.*

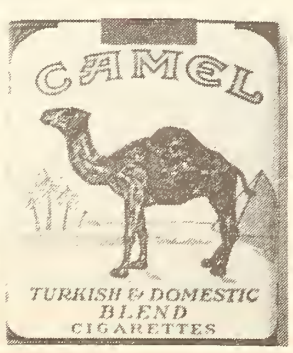
(c) *The excess of disability measures are dose related.*

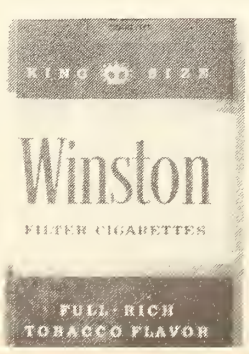
d) *For most age and sex groups, a higher proportion of current and former smokers report longer limitation of activity due to chronic diseases than do people who never smoked.*

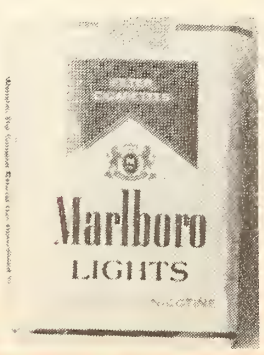
- A tendency was noted for higher proportions of former smokers and those who never smoked, as compared to present smokers, to assess their own health status as excellent.
- Current smokers and former smokers reported more hospitalizations than non smokers in the year prior to interview. Data on the reasons for these hospitalizations have not been analyzed.

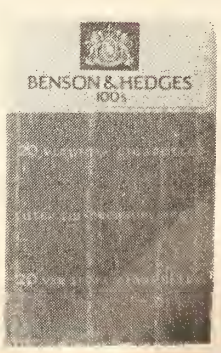
Cardiovascular Diseases

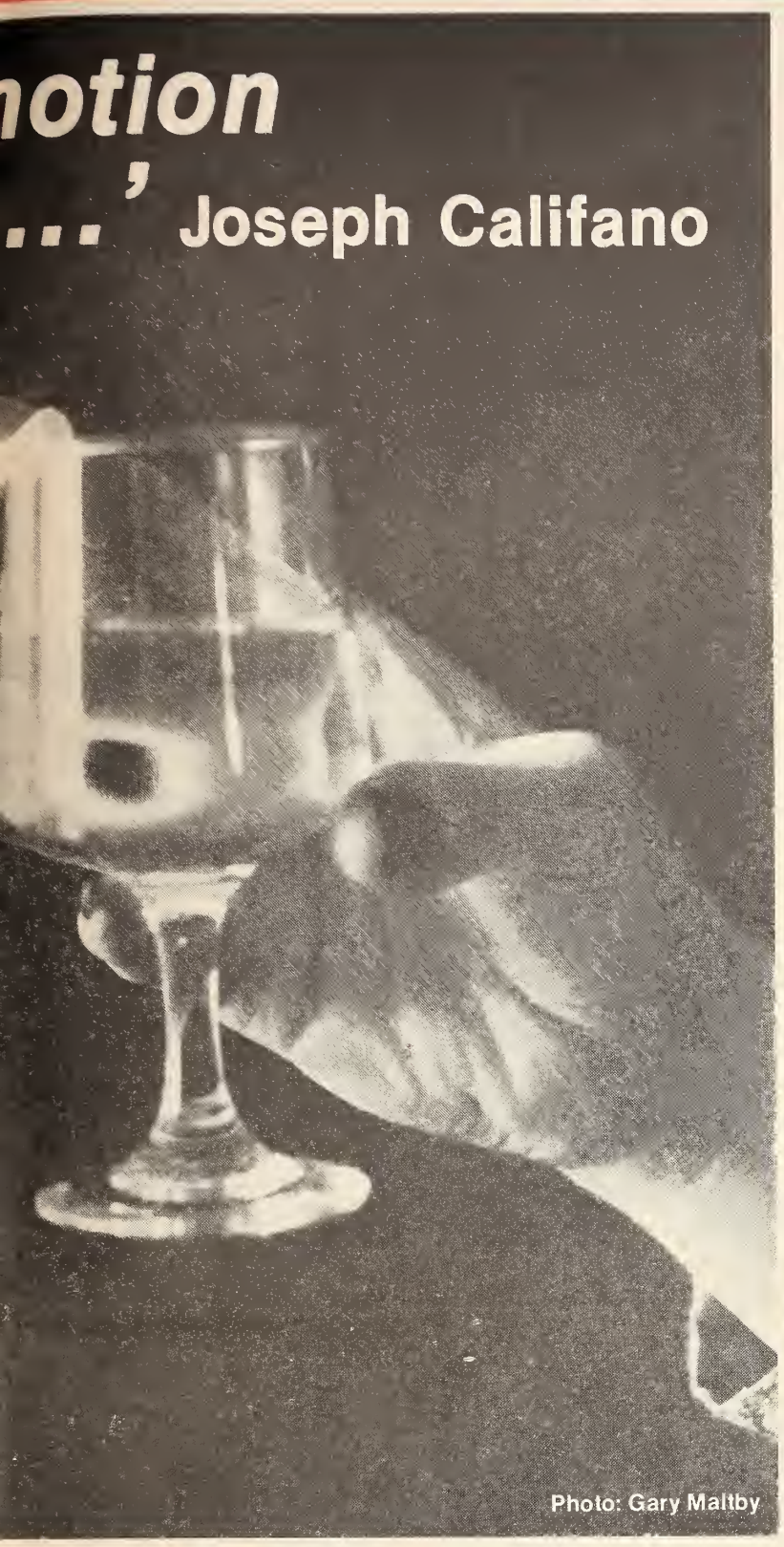
- The data collected from Western countries, particularly the US, but also the United Kingdom, Canada, and others, show that smoking is one of three major independent risk factors for heart attack manifest as fatal and non-fatal myocardial infarction and sudden cardiac death in adult men and women. Moreover, the effect is dose related, synergistic with other risk factors for heart attack, and of stronger association at younger ages.
- Smoking cigarettes is a major risk factor for arteriosclerotic peripheral vascular disease, and is strongly associated with increased morbidity from arteriosclerotic peripheral vascular disease and with death from arteriosclerotic aneurysm of the aorta.
- The data establish adequately that cigarette smoking is associated with more severe and extensive atherosclerosis of the aorta and coronary arteries than is found among non smokers. The effect is dose related.
- Epidemiologic data on the association between cigarette smoking and angina pectoris and cerebrovascular disease manifested as stroke are not conclusive.
- Smoking increases the possibility of a heart attack recurrence among survivors of a myocardial infarction.
- In acute experiments on arteriosclerotic patients with angina pectoris or with intermittent claudication of peripheral vascular disease, smoking or exposure to carbon monoxide reduces the patient's established threshold for the precipitation of angina or claudication.
- Women who smoke and use oral contraceptives are at a significantly elevated risk for fatal and non fatal myocardial infarction and thromboembolism. A synergistic role of cigarette smoking and oral contraceptive use is suggested for subarachnoid hemmorrhage.
- Smokers of low "tar" and nicotine cigarettes experience less risk for coronary than smokers of high "tar" and nicotine cigarettes, k is considerably greater than that of non-smokers.
- In patients with angina pectoris, smoking lowers the threshold for the onset of angina. Both nicotine and carbon monoxide (CO) aggravate exercise-induced angina.
- Cigarette smoking does not induce chronic hypertension. However, in the presence of hypertension as a risk factor for coronary heart disease, smoking acts synergistically to increase the effective risk by joining the risks attributable to hypertension and to smoking alone.
- Cigarette smoking is a major risk factor for ischemic peripheral vascular disease of arteriosclerotic type, cigarette smoking increases appreciably the risk of peripheral vascular disease in diabetes mellitus.
- Cessation of cigarette smoking improves the prognosis of arteriosclerotic peripheral vascular disease and is advantageous to its surgical treatment.
- Cessation of smoking reduces the risk of mortality from coronary heart disease, and after 10 years off cigarettes this risk approaches that of the non-smoker.
- The relationship of smoking to the incidence of stroke is not established; however, an associ-











ation with subarachnoid hemmorrhage has been reported in women.

In summary, for the purpose of preventive medicine, it can be concluded that smoking is causally related to coronary heart disease for both men and women in the US.

Cancer

- Cigarette smoking is causally related to lung cancer in both men and women.
- The risk of developing lung cancer is increased with increasing dosages of smoking as measured by: number of cigarettes smoked per day, duration of smoking, age of initiation of smoking, degree of inhalation, "tar" and nicotine content of cigarettes smoked, and several other measurements.
- Lung cancer mortality rates in women are increasing more rapidly than in men and if present trends continue will be the leading cause of cancer death in women in the next decade.
- Use of filter cigarettes and smoking of cigarettes with lower amounts of "tar" and nicotine decrease lung cancer mortality rates among smokers; however, these rates are significantly elevated compared to rates for non-smokers.
- Ex-smokers experience decreasing lung cancer mortality rates which approach the rates of non smokers after 10 to 15 years of cessation. The risk of developing lung cancer in ex-smokers is proportional to the overall dosage of life time cigarette smoking exposure.
- Certain occupational exposures can act synergistically with smoking to significantly increase lung cancer mortality rates far above those resulting from either exposure alone.
- Cigarette smoking is a significant causative factor in the development of cancer of the larynx in men and women and is directly related to several measures of dosage.
- There appears to be a synergistic effect between smoking and alcohol intake for laryngeal cancer as well as between asbestos exposure and smoking.
- There is a substantial decrease in the risk of developing cancer of the larynx with long term use of filter cigarettes compared to the use of non-filter cigarettes; ex-smokers, after 10 years of cessation, have mortality rates which approximate those of non-smokers.
- Epidemiological studies indicate smoking is a significant causal factor in the development of oral cancer. The risk increases with the number of cigarettes smoked per day.
- A synergism exists between smoking and alcohol consumption for oral cancer.
- Cigarette smoking is a causal factor in the development of cancer of the esophagus, and the risk increases with the amount smoked.
- A synergism also exists for esophageal cancer and the use of alcohol and cigarette smoking.
- Epidemiological studies have demonstrated a significant association between cigarette smoking and bladder cancer in both men and women.
- Cigarette smoking acts independently and synergistically with other factors, such as occupational exposures, to increase the risk of developing cancer of the esophagus.
- Cigarette smoking is associated with cancer of the kidney for men. No data exist to substantiate a relationship for women.
- Smoking is related to cancer of the pancreas, and several epidemiological studies have demonstrated a dose-response relationship.

Pregnancy and Infant Health

- Babies born to women who smoke during pregnancy are on the average 200 grams lighter than babies born to comparable women who do not smoke. Distribution of birth weights of smokers' babies is shifted downward, and twice as many of these babies weigh less than 2,500 grams compared with babies of non smokers. There is abundant evidence that maternal smoking is a direct cause of the reduction in birth weight.
- Birth weight is affected by maternal smoking independent of other determinants of birth weight. The more the mother smokes, the greater the baby's birth weight reduction.
- The ratio of placental weight to birth weight increases with increasing levels of maternal smoking. This increase may signify a response to reduced oxygen availability due to carbon monoxide and may have some survival value for the fetus.
- There is no overall reduction in the duration of gestation with maternal smoking, indicating that the lower birth weight of smokers' infants is due to retardation of fetal growth.
- The pattern of fetal growth retardation that occurs with maternal smoking is a decrease in all dimensions: body length, chest circumference, and head circumference are smaller if the mother smokes.
- According to studies of long term growth and development, smoking during pregnancy may affect physical growth, mental development, and behavioral characteristics of children at least up to the age of 11.
- Overwhelming evidence indicates that maternal smoking during pregnancy affects fetal growth rate directly and that fetal growth rate is not due to characteristics of the smoker, rather than to the smoking, nor is it mediated by reduced maternal appetite, eating, and weight gain.
- When adjustments are made for age-parity differences in mothers, their socio-economic status and previous pregnancy histories, the risk of perinatal mortality attributable to smoking is highly significant, independent of these factors, and is dose related.
- Maternal smoking increases the risk of fetal death through maternal complications such as abruptio placenta, placenta previa, antepartum hemmorrhage, and prolonged rupture of membranes.
- Although maternal smoking does not produce a lowering of mean gestational age, preterm births are increased in frequency among smokers and a large proportion of the neonatal deaths occur among these preterm births.
- Maternal smoking contributes to the risk of infants of these mothers being victims of the "sudden infant death syndrome."
- Maternal smoking can be a direct cause of fetal or neonatal death in an otherwise normal infant.
- The accumulated evidence does not support a conclusion that maternal smoking increases the incidence of congenital malformations.
- The epidemiologic studies on adequacy of lactation do not provide data for a conclusion on the effect of maternal smoking.
- Although some animal studies reveal diminished milk production (but no reduction in release) following nicotine administration, human experimental studies have not thus far produced evidences for a reduction in lactation with forced smoking of large numbers of cigarettes over short periods of time.
- There does exist a direct dose-response relationship between the number of cigarettes smoked and nicotine in breast milk.

Other Complications

- Cigarette smokers have a higher prevalence of non-neoplastic bronchopulmonary disease, chronic bronchitis, and emphysema than non smokers and have an increased chance of dying from these diseases than non smokers. These risks are significant for both men and women who smoke, although higher rates generally exist for men than women.
- Cessation of smoking definitely improves pulmonary function and decreases the prevalency of respiratory symptoms. Cessation reduces the chance of premature death from NBPD.
- Cigarette smokers have an increased frequency of respiratory symptoms, and at least two of them, cough and sputum production, are dose related.
- Pulmonary function abnormalities, as measured by various tests, are greater among cigarette smokers than non smokers.
- Impairment of pulmonary function can be detected among smokers even in young age groups, and respiratory symptoms can be demonstrated in teenagers and adolescents who smoke.
- Tobacco products may serve as vectors by becoming contaminated with toxic agents found in the workplace, thus facilitating entry of the agent into the body by inhalation, ingestion, and/or skin absorption.
- Epidemiological studies have found that cigarette smoking is significantly associated with the incidence of peptic ulcer disease and increases the risk of dying from peptic ulcer disease. This risk is, on the average, twice as high for smokers compared to non smokers, and appears to be greater for gastric than for duodenal ulcer disease.
- The risk of peptic ulcer disease is dose responsive and exists for both men and women.
- While the pathogenetic mechanisms have not been clearly elucidated, the association between smoking and peptic ulcer disease is significant enough to suggest a causal relationship.
- Evidence that smoking retards healing of peptic ulcers is highly suggestive.
- Tobacco and tobacco smoke extracts have been found to act as antigens including both precipitating and reaginic antibodies in animals and man. These tobacco products can also sensitize lymphocytes participating in cell-mediated immune functions.
- Tobacco and its combustion products present such an array of natural and derived components, additives, and contaminants that the precisely defined role for tobacco in immune and allergic processes cannot be delineated.
- Sidestream smoke (directly from the source) to which the non smoker is mainly exposed contains higher concentrations of irritating or hazardous substances than mainstream smoke (exhaled by smokers).
- Children of parents who smoke are more likely to have bronchitis and pneumonia during the first year of life; this effect is independent of social class, birthweight, and parental cough and winter phelgm production.
- Simple extrapolation of dose-response relationships, which are traditionally used in assessing the hazards of smoking to the smoker, cannot be employed in assessing hazards in non-smokers.
- Cigarette smoking in enclosed spaces can produce carbon monoxide (CO) levels well above the ambient air quality standard, even when ventilation is adequate.
- Little or no physiologic response to smoke was detected in healthy non smokers exposed to cigarette smoke. Higher heart rates detected may be due to psychologic factors.

World Health Assembly recommendation:

Train witch doctors for fight on alcoholism

By Thomas Land

GENEVA — Witch doctors should be entrusted and trained throughout the developing continents to combat the rapid rise of alcoholism, according to a proposal to be considered shortly by the World Health Assembly. Its authors say that Western-trained doctors cannot fight alcoholism alone in the Third World, partly because there are too few of them — and partly because many of them are affected by it.

The World Health Assembly is the highest decision making body of the World Health Organization (WHO), and it will meet in Geneva during May. The proposition on novel remedies against the disturbing rise of alcohol abuse in the Third World has been considered by the WHO executive board this year. It has been put forward by specialists of the WHO secretariat, claiming the effects of increasing alcohol abuse in the poor countries are "only now beginning to be realized."

It observes: "The real cost of alcohol has gone down in most parts of the world despite increased taxation. Industrial technologies of liquor production and the activities of the multinational companies supplant traditional methods of brewing and distilling, and vastly increase the supply.

"In Brazil," the report goes on, "first admissions with a diagnosis of alcoholism trebled between 1960 and 1970; in Kuwait, road accident rates trebled from 1965 to 1975 with alcohol very clearly implicated; and in most countries from which valid data can be obtained, cirrhosis now ranks among the five leading causes of death between the ages of 25 and 64 years."

Witch doctors such as this Ghana "bush chemist," may be enlisted by the WHO to help reduce alcoholism, a special risk in impoverished Third World societies.

The report estimates also that perhaps one-third of all road accidents in Zambia and up to two-thirds in Venezuela are caused by excessive drinking; and it blames half of all cases of rape, and 85% of all cases of homicide on alcohol abuse.

The danger signals of rapidly increasing alcoholism throughout the poor world, and particularly among the dominant and recently risen professional and political managerial classes of newly independent countries, have been apparent for some years. Dr Kenneth Kaunda, the teetotaller president of Zambia, for example, has repeatedly and publicly warned over the past five years the local political and industrial managers deriving their power from the presidential office that he would resign unless they curbed their excessive drinking habits.

And the Western-trained medical doctors in the developing world tend to share the influence, wealth, and anxieties, as well as the drinking habits, of the managerial classes. They are also too few in number to make a real impact on the changing social and medical standards of their regions. WHO specialists consider that fewer than 10% of the two billion rural dwellers of the Third World live within walking distance of Western-trained doctors. Instead, the peasants turn for help to the practitioners of traditional medicine — the witch doctor, the scorcerer, the herbalist and the spiritual healer.

Those are the people whose skills and influence the authors of the WHO report want to deploy against the demon drink. A previous World Health Assembly has already voted to enhance the effectiveness of the traditional healers.

A specialist here explains that, in many African countries, there are traditional "birth attendants," midwives whose skills are passed from one generation to another. "Instead of devising expensive plans to introduce a new layer of professional midwives," he goes on, "we'll take people already trusted by their communities and give them training for emergencies. We'll teach them how to recognize labor complications and how to deal with them."

Or as Dr Halfdan Mahler, the WHO director-general, put it: "The training of traditional healers may seem very disagreeable to some policy makers; but if the solution is the right one to help people, we should have the courage to insist that this is the best policy in the long run, and is by no means an expedient acceptance of an inferior solution."

If accepted, the WHO proposal would thus merely extend the present policy on traditional medicine in the developing countries by giving specialist training to witch doctors, enabling them to recognize and treat alcoholism.

Alcoholism is a special health risk for populations living in poverty and squalor. For "excessive drinking," the WHO report says, "can have a special impact when nutrition is poor" by lowering resistance to disease, increasing mental retardation in cases of high consumption during pregnancy, and increasing the tendency to suicide.

The report warns the current era of family breakdowns and widespread migrations by destitute, landless peasants away from the backward countrysides of Africa, Asia, and Latin America to the anonymity of the expanding cities may well exacerbate the problem in future years.

Acupuncture project put to sudden end

By Lachlan MacQuarrie

HONG KONG — In a move which surprised most local observers of the addiction field here, the Hong Kong government has suddenly precipitated the closing of the experimental project on Acupuncture Electric Stimulation (AES) treatment.

The project had been set up in July, 1977, with a grant from the National Institute on Drug Abuse (NIDA) in the United States, and with acupuncture pioneer Dr Wen Hsiang-lai as principal investigator.

The unexpected closure was triggered by the Action Committee Against Narcotics (ACAN), Hong Kong's overall drug coordinating body, whose members decided not to commit further funds to the project even though ACAN's own recently released *Narcotics Report* had stated that, "the whole project was underwritten by the Hong Kong government, including the balance of expenditure required for its first year of operation and its extension for a further year (until June, 1979) if necessary."

ACAN's report had also been optimistic about the future. "Whilst definite conclusions cannot be drawn until the research project is completed and assessed, it can be said that preliminary results are encouraging," the report stated.

"AES promises to be a simple and effective means of treatment, and offers hope for the setting up of an additional treatment modality in Hong Kong for the treatment of a large number of addicts. It should be borne in mind that the Chinese tend to be more receptive to the traditional use of acupuncture, and that AES is geared towards the treatment of heroin addiction which at present is the main type of drug abuse in this territory," ACAN's report continued.

ACAN's decision was particularly surprising because expectations had been that the AES treatment started as an experimental project would, without a break in service, evolve into a permanent treatment modality. Meetings had been held between government medical and narcotics officials and representatives of the Society for the Aid and Rehabilitation of Drug Abusers (SARDA) to discuss the transfer of the AES project to SARDA as an ongoing service to the community, subsidized by the Hong Kong government.

Government spokesmen have put forward no reasons for the closure which became effective Jan 1, except to point out Dr Wen's report on the project has been submitted to NIDA, and to ACAN, and will now have to be evaluated; and in the meantime, ACAN's members have decided that the experiment had continued long enough and they saw no purpose in spending further tax money.

The Government Narcotics Branch has indicated until both ACAN and NIDA conclude the AES technique is cost-effective for treating a large number of out-patient drug addicts on an out-patient basis, no decision will be made about opening future AES clinics.

Acupuncture expert Dr Wen Hsiang-lai was principal investigator of the Hong Kong experimental project in Acupuncture Electric Stimulation treatment.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

The Day I Died

Subject Heading: Impaired driving, youth and alcohol.
Details: 15 minutes, 16 mm, color, sound.
Synopsis: The reality of what can happen under the influence of alcohol is dramatically presented in this film of a 17-year-old boy killed in a car accident. Narrated by the dead boy, the film attempts to give the viewer an idea of how it might feel to be killed senselessly. One day the boy drives his first car to the beach and accepts some alcohol from friends because he is "ashamed to tell them I wasn't used to the stuff." Under the effects of alcohol, he has a fatal accident. His voice continues as he watches his own death and funeral. He pleads with God for another chance.
General Evaluation: Fair (3.1). Because of the film's dramatic device dealing with death, and emotional impact, the A/V Group was divided in its ratings of several aspects of the film including the overall evaluation. However, it was agreed generally the film was contemporary and technically well produced. Its length was suitable for most educational uses, but its efficacy as an educational aid was debatable.
Recommended Use: This film should not be shown to audiences under 11 years of age. Again, the A/V Group was divided on the need for a resource person.

Dope Is For Dopes

Subject Heading: Attitudes and values.
Details: 14 minutes, 16 mm, color, sound.
Synopsis: In this animated film, Fat Albert and the Cosby kids meet a new boy who seems to have unlimited money which he shares. A new motor bike is delivered to the new boy, and Fat Albert rides it, and breaks it. Fat Albert apologizes to the new boy's older brother and is asked to deliver a package in payment for the bike. As Fat Albert delivers the package he is arrested because the package contains dope. Fat Albert is asked to help capture the pushers, and loses the friendship of the new boy. However, the other kids realize Fat Albert did the right thing, and remain as his friends.
General Evaluation: Fair to good (3.3). A contemporary and technically well produced film with a suitable length for most educational uses, this film could be used as an effective teaching aid. The A/V Group was disappointed in the film as a drug education tool. Reservations were expressed concerning the film's conclusion that "dope is bad" without an explanation for this conclusion.
Recommended Use: With the presence of a resource person, this film could benefit those under 14 years of age.

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Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.
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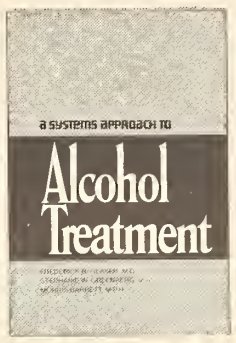
A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



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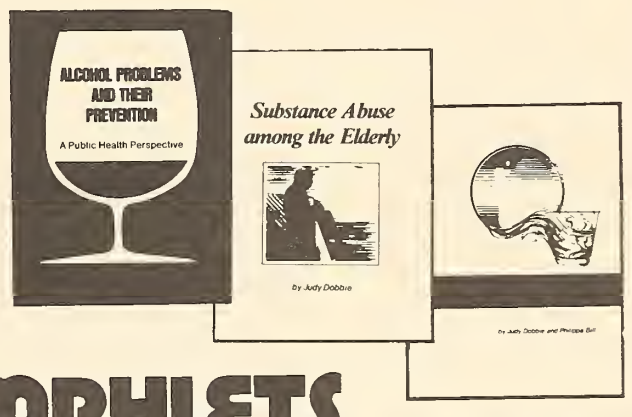

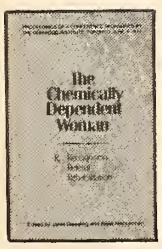

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New Books

by RON HALL

Consider the Alternative

. . . by Lee M. Silverstein

This personal testament is intended as a guide to self-development, and a manual in counselling. The author describes the methods he has found successful in working with people who have difficulties in living, and he relates his personal experiences in dealing with addictions and other problems of life. Alcoholics Anonymous was the beginning of the recovery process and through AA the author became aware of the necessity of involvement with other people and the importance of sharing. During the course of the book, he describes re-education therapy process which is a type of counselling whose primary tool is involvement rather than detachment. Each chapter concluded with some value classification exercises and sayings.

(CompCare Publications, 2415 Annapolis Lane, Minneapolis, Minnesota, 55441, 1977. 139p. $5.50)

A Better High

. . . by Harvey B. Wright

The author notes this booklet is written with the premise, if a person has certain basics in his or her life, there is no need for: alcohol or other mind-altering drugs, socially unacceptable, attention-seeking behavior, or rebellion. The author makes no apologies for talking about spiritual needs, and principles and guidelines are presented to enable the reader to lead a meaningful life without using chemicals. The booklet assumes the reader has enough basic knowledge about the nature and effects of alcohol and other drugs to make rational decisions about their use.

(Research and Education on Alcohol and Drugs, PO Box 2437, Springfield, Illinois, 62705, 1978. 64p.)

Other Books

Effect Of Labeling The "Drug Abuser": An Inquiry — Williams, J. R. National Institute on Drug Abuse, Rockville, 1976. Adolescent drug abuse: apprehension: self-concept: subsequent behavior. Selected bibliography: (NIDA Research Monograph 6). 39p. $9.

Perinatal Medicine: Management Of The High Risk Fetus And Neonate — Bolognese, R. J., and Schwarz, R. H. Williams and Wilkins, Baltimore, 1977. Includes pregnancy complicated by drug addiction. References: index. IX, 306p. $33.50.

Pot Smoking And Illegal Conduct: Understanding The Social World Of University Students — Nawaz, Mohammad. Diliton, St Catharines, 1978. A Canadian study, from a sociological perspective, of marijuana use presented with extensive data and thorough analysis. Appendices include additional statistical material and research questionnaire. Bibliography: index. XIII, 209p.

Hashish: Studies Of Long Term Use — Stefanis, C. Raven Press, New York, 1977. Sociocultural aspects of hashish use in Greece: sample selection and methods: results: acute experiments; withdrawal studies. Bibliography: index. XIII, 181p. $15.05.

Toxic And Hallucinogenic Mushroom Poisoning — Lincoff, G., and Mitchell, D. H. Van Nostrand Reinhold, Toronto, 1977. References: index. 267p. $21.25.

Proceedings Of The 2nd World Conference Of Therapeutic Communities Vamos, P., and Brown, J. E. (eds.) Portage Press, Montreal, 1978. The Addiction Therapist, Special edition, Vol 2 (3&4) : 1978. Conference held Aug. 21-26, 1977 in Montreal, Quebec. History, women's issues, re-entry and other special interest sessions, socio-cultural influences. Part one. 247p. $10.

Proceedings Of The 2nd World Conference Of Therapeutic Communities — Vamos, P., and Brown, J. E. (eds.) Portage Press, Montreal, 1978. The Addiction Therapist, Special edition, Vol 2 (3&4) : 1978. Conference held Aug. 21-26, 1977 in Montreal, Quebec. Problems of role and identity for the non-credentialed worker in the TC: international cooperation, special interest sessions. Part two. 68p. $10.

Currents In Alcoholism: Biological, Biochemical, And Clinical Studies, Vol 3 — Seixas, F.A. (ed). Grune and Stratton, New York, 1977. Vol III — papers of the 8th annual medical-scientific conference of the National Alcoholism Forum, jointly conducted by the National Council on Alcoholism and the American Medical Society on Alcoholism, May 2-4, 1977, San Diego, CA. Animal studies and neurological findings, neurochemistry, metabolism of ethanol; three explorations of technique, pharmacological interactions, effects on the heart, parameter of alcohol actions on the body, alcohol and performance, diagnosis of alcoholism, treatment of withdrawal, references index, 601p. $31.50.

The Delivery Of Alcoholism Services: Meeting Whose Needs? — Christmas, J. J. Dept of Mental Health and Mental Retardation Services, New York, 1977. Presented at Seminar on Alcoholism Treatment in Prepaid Group Practice-Health Maintenance Organizations, February 1977, Boston. 15p. $2.50.

The Aetiology Of Psychoactive Substance Use — Fazey, C. United Nations Educational, Scientific and Cultural Organization, Paris, 1977. A report and critically annotated bibliography on research into the aetiology of alcohol, nictone, opiate and other psychoactive substance use, further articles on topics already represented in the annotated section are listed in an unannotated bibliography, index by country and drug, list of journals. 226p. $15.75.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

Detox Training Program — March 26-30, April 30-May 4, Toronto, Ontario. Information: Mr G. Gooding, assistant to the coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

Workshop on Dependency: Treat Or Challenge — March 30, Toronto, Ontario. Information: Frank Fallon, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

Our Children Our Future — April 9-11, Toronto, Ontario. Information: Ontario Association of Children's Aid Societies, 663 Yonge St, Toronto, Ont, M4Y 2A4.

Family Therapy Workshop — May 5-6, Toronto, Ontario. Information: Dean Darnell Social Work Consultants Ltd, 235 Church St, Oakville, Ontario, L6J 1N4.

10th International Congress For Suicide Prevention And Crisis Intervention — June 17-20, Ottawa, Ontario. Information: Secretariat, IASP Congress '79, 700-71 Bank St, Ottawa, Ont, K1P 5N2.

70th Annual Conference Of The Canadian Public Health Association — June 18-22, Winnipeg, Manitoba. Information: Mr G. H. Dafoe, Executive Director, CPHA, 1335 Carling, Suite 210, Ottawa, Ontario, K1Z 8N8.

Input '79 - 3rd Biennial Canadian Conference On Occupational Alcoholism and Drug Abuse — Sept 23-26, Ottawa, Ontario. Information: Input '79 Headquarters, Conference & Seminar Services, Humber College of Applied Arts and Technology, Box 1900, Rexdale, Ont, M9W 5L7.

Canada's Safety Council's 11th Annual Safety Conference — Sept 30-Oct 3, Quebec City. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario, K1G 3V4.

United States

2nd National American Indian School On Alcoholism And Drug Abuse — March 5-9, Albuquerque, New Mexico. Information: David M. Vallo, President, American Indian Training Institute, 2222 Watt Ave, Suite B-4, Sacramento, California, 95825.

4th Annual Minority Drugs Workshop — March 16-17, Dallas, Texas. Information: Leonard C. Long, West Dallas Community Centers, Inc, 300 Dallas West Shopping Center, Dallas, Texas.

Alabama School Of Alcohol Studies — March 20-23, Tuscaloosa, Alabama. Information: Peter Balsamo, Director, Continuing Education in Human Services, University of Alabama, PO Box 2967, University, AL, 35486.

The 1st New Jersey Conference On Alcohol Abuse In The Hispanic Community: Challenge For The 80's — March 22-23, Rutgers University, New Brunswick. Contact: David A. Matos Jr, Coordinator, Hispanic Office, Alcohol, Narcotic and Drug Abuse, 129 East Hanover St, Trenton, New Jersey, 08608.

4th Annual Southeastern Occupational Program Training Institute — April 2-6, Atlanta, Georgia. Information: Ed Pierce, department of Human Resources, Alcoholism and Drug Section, 618 Ponce De Leon Ave, NE, Atlanta, Georgia, 30308.

Substance Abuse And Human Sexuality — April 26-27, Cincinnati, Ohio. Information: Ann Blankenhorn, Alcoholism Consultant, Consultation and Education, 530 Maxwell Ave, Cincinnati, Ohio, 45219.

American Medical Society On Alcoholism — April 26-May 2, Washington, DC. Information: J. G. Chen See, MD, AMSA, 733 Third Avenue, New York, NY, 10017.

1979 National Alcoholism Forum And Annual Meeting Of The National Council On Alcoholism — April 27-May 2, Washington, DC. Information: National Council on Alcoholism, 733 Third Avenue, New York, NY, 10017.

First National "Women in Crisis" Conference — May 17-19, New York City. Information: Jane Velez, Conference Administrator, "Women in Crisis", 444 Park Avenue South, New York, NY, 10016.

14th Meeting — Association of Halfway House Alcoholism Programs — June 3-7, Lincoln, Nebraska. Information: AHHAP, 786 East 7th St, St Paul, Minnesota, 55106.

The 41st Annual Scientific Meeting Of The Committee Of Problems Of Drug Dependence, Inc — June 4-6, Philadelphia, Pennsylvania. Information: Dr Leo E. Hollister, Veterans Administration Hospital, 3801 Miranda Avenue, Palo Alto, California, 94303.

6th Annual Puerto Rican Substance Abuse Conference — June 5-8, Santurce, Puerto Rico. Information: '79 Conference, National Association of Puerto Rican Drug Abuse Programs, 1766 Church St, NW, Washington, DC, 20036.

Ohio Drug Studies Institute 1979 — June 11-15, Columbus, Ohio. Information: ODSI Training/Division of Mental Health, 13th Floor, Room 1346, 30 East Broad St, Columbus, Ohio, 43215.

Southern Oregon Institute of Alcohol Studies — June 17-22, Ashland, Oregon. Information: Ruthanne Lidman, Coordinator, SOIAS, 3355 View Drive South, Salem, OR, 97302.

21st Annual International School Of Alcohol Studies — July 15-20, Grand Forks, North Dakota. Information: F. Wittmann, Conference Coordinator, University of North Dakota, Continuing Education, Box 8277, University Station, Grand Forks, ND, 58202.

Annual Summer Institute Of Drug Dependence — July 29-August 3, Colorado Springs, Colorado. Information: Summer Institute of Drug Dependence, PO Box 2172, Colorado Springs, CO, 80901.

6th National Drug Abuse Conference — Aug 26-30, New Orleans, Louisiana. Information: NDAC '79, 115 S Chestnut Street, Lafayette, LA, 70501.

30th Annual Meeting Of The Alcohol And Drug Problems Association of North America (ADPA), Aug 26-30, Washington, DC. Information: Driscoll and Associates, 1925 North Lynn St, Suite 1001, Arlington, Virginia.

4th World Conference Of Therapeutic Communities — Sept 16-21, New York City. Information: Charles Devlin, Coordinator, Daytop Village, Inc, 54 West 40th Street, New York, NY, 10018.

Association Of Labor-Management Administrators And Consultants On Alcoholism (ALMACA) — Oct 2-6, Detroit, Michigan. Information: ALMACA, 1800 N Kent St, Suite 907, Arlington, Virginia, 22209.

Annual Meeting Of The Society Of Forensic Toxicologists — Oct 31-Nov 2, Williamsburg, Virginia. Information: Robert V. Blanke, Medical College of Virginia, MCV Station, Box 696, Richmond, VA, 23298.

National Conference On the Problems And Preventions Of PCP Abuse — Nov 3-4, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, CA, 94117.

Abroad

Fifth Scottish School On Alcoholism — April 1-6, Ayr, Scotland. Information: G. E. Isles, Executive Director, Scottish Council on Alcoholism, 34 Queen Street, Edinburgh EH2 1JX, Scotland.

International Conference On Animal Models In Alcohol Research — June 4-7, Helsinki, Finland. Information: John David Sinclair, Research Laboratories of the State Alcohol Monopoly (ALKO), Box 350, SF-00101 Helsinki 10, Finland.

The 6th World Congress Of Acupuncture — June 17-22, Paris, France. Information: Pierre Bidault de Villiers, Service Presse "Mondial", 3 rue de la Grande Truanderie, 75001 Paris, France.

4th World Conference On Smoking And Health — June 18-21, Stockholm, Sweden. Information: 4th World Conference on Smoking and Health, c/o RESO Congress Service, S-105 24 Stockholm, Sweden.

25th International Institute On The Prevention And Treatment of Alcoholism — June 18-22, Tours, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 10001 Lausanne, Switzerland.

The 1st International Conference On First Aid At the Scene Of An Accident — June 19-23, Oslo, Norway. Information: The Norwegian Automobile Association. NAF, PO Box 494, N-Oslo 1, Norway.

6th Institute On Drugs, Crime And Justice In England — July 3-20, London, England. Information: Arnold S. Trebach, Director, Institute on Drugs, Crime and Justice in England, School of Justice, The American University, Washington, DC, 20016.

Third World Congress Of The International Commission For The Prevention Of Alcoholism and Drug Dependency — Aug 26-31, Acapulco, Mexico. Information: ICAP Executive Director, 6830 Laurel Street, NW, Washington, DC, 20012.

10th International Conference On Health Education — Sept 2-7, London, England. Information: The Conference Centre, 43 Charles Street, Mayfair, London W1X 7PB, England.

International Conference On Alcoholism And Drug Dependency — Sept 3-7, Tegucigalpa, Honduras. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Symposium On Addiction: Biochemical Mechanisms of Dependence and Brain Damage — Sept 13-14, Oxford, England. Information: The Helping Hand Organisation, c/o The Alcohol Education Centre, 99, Denmark Hill, London, SE5 8AZ, England.

9th International Institute On The Prevention And Treatment Of Drug Dependence — October, Madrid, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

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Mexico's problems: alcohol for adults... ...solvent abuse among youth

By Harvey McConnell

MEXICO CITY — You see them everyday in the poorer areas of seven major Mexican cities: 12- and 13-year-old boys who roam in small bands, and homeless, drift aimlessly from one city to another.

The young boys are not violent, and can earn the few pesos necessary to indulge their addiction with odd jobs like cleaning car windshields. However, their addiction to sniffing glue and gasoline is a major concern of Mexican authorities.

The solvent abusers number in the thousands and are easy to spot — each carries a small plastic bag with cotton impregnated balls inside from which they sniff at random.

Solvent abuse and marijuana use among young people are major concerns of Mexican authorities but these are eclipsed overall by the problems produced by alcohol abuse among the population.

It is a concern shared by mental health officials but precious few others, according to Carlos Campillo Serrano, coordinator of services for the mental health institute here.

About 1,000 new inhabitants arrive in Mexico City daily (above), some of them bringing with them problems of heavy drinking and drug abuse from tens of thousands of villages throughout the country where the problems are most acute, according to Dr Carlos Campillo Serrano, coordinator of services for the mental health institute here (inset).

Remedy shunned

Dr Campillo explains: "History of alcohol use and abuse in Mexico is quite different than in the Anglo-Saxon context. For instance, here, as in many other Roman Catholic countries in Latin America, we don't have any sort of temperance movement. There are no organizations to condemn excess drinking: it is very open, and one's reputation does not suffer from being drunk. If you are suffering from a hangover and don't turn up for work, you say you have a 'cold' and everyone knows what has happened.

"You can talk about the damage from alcohol in conceptual terms, but in all honesty it means nothing to most people. It applies to doctors as well. We have held conferences attended by North American experts, and when they tried to explain models for primary prevention most of the doctors were nonplussed, and said they felt we didn't need this sort of remedy."

Bizarre drinking

Dr Campillo says alcohol use has long been a problem and all the signs point to increasing consumption. Beer has overtaken *pulce*, the fermented juice of a succulent plant, as the main beverage of the working man. Tequila, rum, and brandy are cheap.

"It is very easy to get drunk here, and I must admit that the laws often are not enforced as vigorously as they should be. I would guess that on holidays, especially, at least 25% of the drivers are drunk by any standard of measurement."

The problem is most acute in the tens of thousands of small villages around the country where Dr Campillo estimates more is spent per capita on alcohol when compared with Mexico City. "Drunkenness is expected, accepted, and tolerated," he adds.

Some of the drinking patterns are bizarre in the extreme. One Indian village near Mexico City is a good example.

Dr Campillo: "We only found out recently that for years the Indians there have a standard mixture: *pulce*, pure alcohol and ether! They use this combination to get a quick and easy drunk on the weekends. Ether is obtained quite easily from the local pharmacy.

"This community, like many Indian villages, has little confidence in the government, or 'white people', and it has already chased out one team we sent in to try and help solve the problem.

"The Indians (who number 19 million among the 64 million population) can prove very resistant: it is very difficult, for example, to carry out smallpox vaccination campaigns. But we don't give up, and we are now trying to send in another team to this particular village to see if we can do anything."

In Mexico City, the skid row alcoholics have a combination which is just as bizarre as the Indian concoction: they mix all sorts of alcohol with gasoline.

Dr Campillo says that without the moral pressures of temperance it is very difficult to try and teach people to be moderate drinkers.

"The official position is to look at alcoholism as a disease and I think we should spend our efforts in secondary prevention, because it is very difficult to talk in any terms of primary prevention.

"Maybe one of our tasks for the future will be studies which would show the accidental deaths due to alcohol, and the economic damage alcoholism can produce."

Universal drink

Beer is the universal drink and it is a rich source of tax revenue. Several Mexican breweries now make significant contributions to the United States dollar balance of payments with canned beer bought by Mexican Americans.

One area in which the centre can move is in trying to help the solvent abusing young people.

Dr Campillo says the most important factor is trying to provide some sort of family life. All of the young boys have left home to live with a gang.

He says sniffing glue or gasoline "produces a quick effect and there is not much hangover either. The big question is how much brain damage is caused. Animal studies have shown a high degree of damage but it is difficult to extrapolate this into human terms."

For the past year, the institute has supported a young couple, both of whom are psychologists, who act as parents to some 20 young boys.

Dr Campillo says it is too early yet to draw conclusions "but the children seem quite happy and there are signs they are gaining confidence and in some way may be rehabilitated."

In another study, the institute has picked one suburb and begun a program to see if the children who abuse solvents can be identified early. Teams are working with local doctors, priests, and teachers, and good contact has been made with two gangs who use solvents.

One of the difficulties, Dr Campillo explains, is that because the young abusers live in gangs with a leader there is a lot of rivalry between them.

"However, they are completely harmless, and with no ties to society they roam around the country, mainly to towns which are tourist attractions, although we don't know why really."

Studies have shown marijuana is the main drug used by young people, "although the percentage is low if you compare Mexico with the United States," Dr Campillo adds.

"We think the pattern of use among the 18- to 24-year-old age group is pretty steady and it is not growing."

A somewhat harder opinion is taken by government officials who view marijuana as a threat and are trying to eradicate it. It has produced friction with the US over the use of paraquat on marijuana crops that could prove serious (**The Journal**, Dec, 1978).

Another group trying to help young people with abuse problems is the *Centros de Integracion Juvenile*. It is a private institute which is funded in part by the government, as well as by donations solicited from such events as fashion shows and concerts by pop groups.

Carmen Garcia Linan, director of information for the centre, says there are 32 branches around the country, including eight in Mexico City.

Attempts are made at primary prevention, especially with marijuana users and solvent abusers, as well as treatment and rehabilitation programs.

Mrs Garcia says dealing with the solvent abusers "is very hard work and frankly can be very disappointing because most of these young people simply don't want to be helped."

But the children can be helped. The centre helps finance a psychologist who has taken to the streets. "He loves the kids and the kids love him," Mrs Garcia says.

However, the psychologist hides under the pseudonym German Leal when he publishes his studies and speaks at conferences.

Mrs Garcia: "He does this because he does not want the children to find out he is a psychologist as they might not trust him again. He goes to great lengths to keep his identity secret."

Mrs Garcia: "We are living in a transition period here in Mexico where the traditional structures of society are changing. Women, for instance, have, or want to have, more freedom. Many women now earn a salary but they don't have the freedom to spend it."

Sexual mores are changing as well, which puts much greater pressure on young middle class women who can easily obtain the contraceptive pill.

Mrs Garcia points out: "All of the problems in Mexico are reflected in Mexico City, and this is why most of our pilot projects are carried out here.

"We are making efforts to get to the children through their parents. Group and family therapy is being tried out with young drug abusers.

"In some areas of the city we use a people's theatre concept to try and put over ideas about mental health. The actors roam the streets and improvise dialogue with the public.

"The theme of the plays are related to mental health and we try and create a 'mirror image' of the most frequent problems of the community."

For young drug addicts the centre offers open classes so they can work to obtain elementary or high school degrees.

Mind-boggling

Those with the most serious problems are sent to a ranch in the country where they receive accommodation and a salary for the work they do, as well as a basic education, if that is necessary.

Solvent abuse is not a problem among middle class young people, but tranquillizers are. Mrs Garcia: "Legally you can't buy them over the counter, but they are very easy to obtain. You can go to many pharmacies and buy as many as you like."

There is no prospect that the presures in the country will lessen, and in Mexico City they can only get worse because an estimated 1,000 new inhabitants arrive everyday.

Dr Campillo sums it up: "Already there are estimates that Mexico City has a population between 12 and 15 million people. If the present influx continues until the turn of the century, and that is not so far off, we shall have a population here of 25 million.

"The mind boggles."

THE BACK PAGE

Athlete drug tests will be best yet

By Alan Massam

LONDON — Athletes competing in the summer Olympic Games in Moscow next year are to face sophisticated screening for drugs.

A Soviet foreign trade organization, V/O "Techsnabexport" has ordered nearly $900,000 worth of drug testing instruments from the scientific instrument company, Hewlett-Packard, in the United States.

In all, eight gas chromatographs with liquid samplers, two gas chromatograph/mass spectrometers, one liquid chromatograph, and one computerized laboratory automation system are to be shipped to Russia by the end of this year, a British spokesman for the company reported.

More than 9,000 athletes from more than 130 countries are expected to participate in the 1980 games. Urine from the leading contestants will be tested after every event. Tests will also be carried out on competitors chosen at random.

A spokesman for Hewlett-Packard told **The Journal** the Russian drug surveillance would be supervised by Professor V. A. Rogozkin, director of the Scientific Research Institute for Physical Culture, Leningrad, and president of the 1980 Olympic doping committee. He said the professor estimated the tests could establish the presence of any of about 2,000 types of drugs regarded by the International Olympic Committee as potentially a danger to health.

Gas and liquid chromatography are fast and accurate techniques for chemical analysis, separating chemical compounds into identifiable components, he added. Amounts as small as a millionth of a millionth of a gram could be identified.

"If a banned drug is found by this method, the sample is further analyzed by a gas chromatograph/mass spectrometer, which can identify a component by its mass spectrum or 'fingerprint' and determine the amount of the substance," he said.

"Hewlett-Packard's involvement in the Olympic drug control program began in 1972 when the company supplied similar instruments to the Munich games. At the Montreal Olympiad in 1976, the company helped the University of Quebec's Institut National de la Recherche Scientifique (SANT) to carry out the most sophisticated drug control program to date. The institute has been selected by the International Olympic Committee to carry out the drug control program for the 1980 Winter Olympics at Lake Placid, New York."

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The Journal

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Canada slashes its UN drug fund in half

By Jeff Carruthers

OTTAWA — The Canadian government has slashed in half its annual contribution to the United Nations' Fund for Drug Abuse Control.

And the reduction to $100,000 from the $200,000-a-year contribution provided over the past seven years couldn't have come at a more embarrassing time.

Don Smith of the International Affairs Branch of the Department of National Health and Welfare, was just appointed this year's chairman of the UN Commission on Narcotic Drugs.

And he admitted being personally embarrassed at having to bring the bad news to the commission meeting in Geneva earlier this year.

The situation was made worse by the fact that many other countries were, at the same time, announcing increases in their annual contributions.

Australia, for example, has just raised its contribution to $250,000 a year in US funds, for four years.

The official Canadian explanation is that the cutback is the result of the federal government's fiscal restraint program.

Dr Smith says the government is still hoping to find another $100,000 somewhere for later in the year, though the funds will have to come from outside the health department.

Other government sources say the hope is unlikely to be realized.

Drugs, it seems, do not rank at the same level of urgency as national unity and other issues still receiving new funds from Ottawa despite the fiscal restraint.

China drug tales are 'nonsense'

By Anne MacLennan

GENEVA — Reports that addicts from The People's Republic of China are either filtering or flooding into Hong Kong are "absolute nonsense," says Peter Lee, Commissioner of Narcotic Drugs for Hong Kong.

He said the same is true of suggestions that China has "vast areas of government-sanctioned opium plantations."

He told The Journal: "This is a facet of Taiwanese propaganda that is retailed from time to time. There's not a shred of truth in it."

He said authorities in Hong Kong, who now believe they are "containing the problem" in Hong Kong, have a detailed picture of its extent and would be quick to spot any influx of either new addicts or new heroin supplies.

"The last propaganda that was put out was about two-and-a-half years ago. It was Taiwan-inspired and said China was trafficking drugs to and through Hong Kong. There was no evidence whatsoever," said Mr Lee.

He also said China had dealt effectively with pre-revolutionary drug problems and that increased exposure to the West will unlikely change that picture.

"They believe their measures of social control are such that they can insulate their people from these things. And I think their record proves they can.

"The record of The People's Republic on drug trafficking and addiction has been a very honorable one and a highly effective one.

"When they took over in 1949, they were faced with horrendous problems of drug addiction. Their anti-narcotics laws were among the first the Communists passed. They were very effectively designed — a combination of crop substitution programs in those areas where opium had previously been grown and (most severe) punishment for traffickers, financiers, managers, and organizers of the drug trade, or manufacturers of heroin. In other words, people were executed."

As for addicts, he said, the authorities "used a psychological approach. They felt they (the addicts) were victims of exploitation and . . . should be treated as victims of any social disease."

Washington report: More funds slated for cities

WASHINGTON — Additional federal funds which will help major cities in particular with their drug abuse efforts may be forthcoming in the current legislative year, in the opinion of Thomas Bryant, president of the Drug Abuse Council.

Dr Bryant told a conference here of the National Association for City Drug Coordination that in his discussions with legislators and members of President Jimmy Carter's administration: "I get a sense" such proposals are in the pipeline.

Most of the funds would be intended for training and program coordination, he said.

Thomas Bryant

At the same time, Bryant said, while more money may be available for specific purposes, the overall amount of federal funding for drug and alcohol programs will probably remain steady. There are certainly no big overall increases in the offing now, or in the future, he said.

Major legislation on mental health will also probably be submitted later this year by the administration to Congress. Dr Bryant served for a year as executive director of the President's Commission on Mental Health.

Dr Bryant said he sees changes in public attitudes to alcohol, drug, and even mental health programs which disturb him — "a feeling they're being stigmatized now."

Paradoxically, however, he believes the majority of the public now accept a level of drug use as normal "which surprises me and which I would never have predicted."

Dr Bryant said the Drug Abuse Council is now nearing the end of its existence. A final report with a number of recommendations, some of which Dr Bryant said would be controversial, is expected to be published in the fall.

NIDA gets leader, NIAAA waits

WASHINGTON — The long wait for a director of the United States National Institute on Drug Abuse (NIDA) has ended with the official appointment of William Pollin by Joseph Califano, secretary, Department of Health, Education, and Welfare.

Dr Pollin has been NIDA Research Director since 1975.

At press time, no move had yet been made by the secretary to appoint a director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and thus bring to an end an embarrassing hiatus over the past months for the two institutes.

It was known for weeks in Washington that Dr Pollin had been chosen to head NIDA by Gerald Klerman, director of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) but Mr Califano hesitated about making it official.

It is known also that a number of highly respected candidates who had been interviewed for the NIAAA post had angrily withdrawn their names following months of silence from Washington.

Mr Califano said the appointment "reflects the institute's expanded research mission. The National Institute On Drug Abuse is in transition from a focus on only one or two drugs to activities that will address a much wider agenda including the abuse of prescription drugs, abuse of synthetic drugs such as phencyclidine, and expanded research on the use of tobacco."

Dr Pollin replaces Dr Robert DuPont who was forced out as NIDA director last summer by Mr Califano. Karst Besterman who had been deputy director under Dr DuPont has served as acting director until now.

INSIDE

THE BREWERS/ARF FILE . . Pages 7 to 13

In a special 20-page issue, The Journal publishes an exchange between the Brewers Association of Canada and the Brewers of Ontario, and the Addiction Research Foundation of Ontario. Documents prepared by both the Brewers and the Foundation are published here in the interests of clarity.

Lalonde passes buck on marijuana inaction

OTTAWA — The long-awaited cannabis bill, which would leave cannabis possession an offence but eliminate the chance of a criminal conviction and record, has been left in limbo until after the federal election.

But, it'll be no surprise if the cannabis issue emerges during the election campaign, with all sides blaming everyone else for the inaction to date.

Explaining the latest delays by the Liberal government, Federal Justice Minister Marc Lalonde told **The Journal** that if he could be assured Parliament would be sitting through June, and, therefore, any legislation would have a chance of being passed, he might consider introducing it again.

However, in view of what he believes is back pedalling by opposition parties on earlier statements that they would provide quick passage for cannabis legislation, Mr Lalonde said there was no point in reintroducing the bill and then having it die on the order paper when Parliament is dissolved.

(At press time, the Liberal government called an election for May 22.)

And the government was having to invoke closure just to get emergency legislation on energy to the Commons, with other important bills still fighting for time.

Mr Lalonde said the Conservative and New Democratic parties were backing away from an earlier surprise agreement to give speedy passage to the drug legislation. Now, according to Mr Lalonde, the opposition parties had indicated they would want to study the bill carefully during normal parliamentary debate.

Meanwhile, the pro-cannabis group NORML (National Organization for the Reform of Marijuana Laws) held a news conference in Ottawa to try to jog the government into action.

Centre piece of the news event was a member of the Social Creditiste party who was backing up the NORML claim that the Social Creditiste party was not against cannabis reform legislation. There had been earlier news reports the right wing, Quebec-based party would block any speedy action on the cannabis legislation.

Elsewhere, Health Minister Monique Begin told a Commons Committee that even when penalties for possession of cannabis are eased, the government would crack down on drugs suppliers and distributors in the hope of preventing widespread abuse of marijuana and hashish.

However, health department officials also admitted that increased cannabis use is probably inevitable and attempts to cut off foreign supplies of the drug would likely encourage more domestic cultivation. Cannabis is usually imported from Mexico and Colombia but can also be grown in Canada and the US where domestic varieties tend to be less potent.

Youths 'inoculated' against pressure to smoke

HILTON HEAD ISLAND, SC — A program in San Jose, California, is trying to "inoculate" young people against smoking.

The aim is to get 11- and 12-year-olds in the pilot program to resist peer pressure ever to start, Alfred McAlister of Harvard School of Public Health said here.

Among the tools given the youngsters are new ways of responding to invitations to take up the habit.

A young person taunted as chicken for not smoking, for example, would reply: "I'd be chicken if I smoked just to impress you."

Young people often start just because they don't know how to avoid it, Dr McAlister told a science writers' seminar sponsored by the American Heart Association.

To counter this and scotch the "he-man" or "liberated woman' image of the advertisements, the children are encouraged to take the approach "she's not really liberated if she's hooked on tobacco."

Dr McAlister said such ploys, along with role playing and instruction by older non-smoking teens, helped to reduce smoking in one San Jose school as compared to the control school where no such instruction was given.

He said a seven session curriculum, with a peer leader, was developed for use in 6th or 7th grades. In the first session, the aim is to demonstrate overt or subtle influences to smoke and to strengthen the student's resistance to these. Later sessions discuss the "how to" of avoiding smoking.

CNS drug abuse in Japan

TOKYO — There continue to be dramatic increases in the number of abusers of central nervous system (CNS) stimulants in Japan, according to the managing director of the Japan Pharmaceutical Information Centre here.

This is in contrast to a relative stabilizing of the number of abusers of narcotics, including opium and hemp, Fuminae Kubo said.

Following up a report given in Paris in 1974 at the 1st World Congress of Environmental Medicine and Biology (The Journal, 1975) in which Dr Kubo said the number of offenders had risen from 704 in 1969, to 8,510 in 1973, he said the 1977 figure was 14,741.

The law making amphetamines and methamphetamines drugs of abuse was passed in Japan in 1951, he said, when abuse problems among veterans were becoming apparent.

Dr Kubo said three quarters of the offenders against the CNS stimulants law are between the ages of 20 and 40. The drugs, or their raw materials, are smuggled from Southeast Asia or Korea, he said.

'We do not have a safe cigarette'

Low tar to cut cancer rate?

WASHINGTON — There will probably be a drop in lung cancer deaths in the next decades because more smokers use low tar and nicotine cigarettes. But, a much higher mortality rate will continue among smokers than non-smokers.

'Safer' cigarettes

A study at the Veterans Administration Medical Center, East Orange, NJ, found fewer abnormalities in the cells of the lining of the bronchial passageways at autopsy on men who had smoked low tar cigarettes.

The report by Pathologist Oscar Auerbach and colleagues in *The New England Journal of Medicine* follows earlier predictions by Dr Gio Gori, of the National Cancer Institute (NCI). Dr Gori said the cigarettes the NCI helped to develop are "safer" in a relative sense (The Journal, May 1978).

Examinations

Dr Gori points out there is no "safe" cigarette but the milder ones are "less hazardous cigarettes."

Dr Auerbach and colleagues examined lung tissues taken from men who died between 1955 and 1960 and another group who died between 1970 and 1977. None of the deaths was attributed to lung cancer.

Important factor

Cells in the lungs of recent smokers had 10 times fewer precancerous abnormalities than those of men who smoked 15 years ago. Dr Auerbach warned, however, "smoking is still the most important factor in lung cancer and we do not have a safe cigarette."

NORML huddles against 'establishment huns'

By Wayne Howell

Speaking at the recent annual meeting of NORML (National Organization for the Reform of Marijuana Laws) in Washington, DC, New York region representative Frank Fioramanti likened the fight to legalize marijuana to a war that would only be won after a long hard struggle.

Going him one better, Reverend Canon Walter Dennis of New York's Cathedral Church of St John The Divine likened the position of NORML to the position of the allied troops on D-Day and encouraged the NORML legions to gird their loins for heavy fighting because although the enemy's back had been broken the final victory had still not been achieved.

We take you now to the forward trenches where Sergeant York of the NORML army is briefing his troops prior to the final assault . . .

"OK men. Our barrage begins at 1300 hours and when it lifts at 1330 hours we go over the top. Stroup company will be on our left and the Margaret Trudeau battalion of Canadian Volunteers will be covering our right flank. Is that clear men? OK, now check those gas masks and make sure they're working: tobacco smoke attacks, paraquat attacks, there's no telling what those establishment huns will throw our way. So let's . . .

"INCOMING!" *Everyone hits the dirt as an establishment fragmentation shell showers them with books, scientific journals, and anti-marijuana literature. When the dust has settled Sergeant York raises his head to survey the damage.*

"Ginsberg, Ginsberg, are you all right . . . answer me."

"He took a direct hit with a leather-bound copy of the LaGuardia report, Sarge — looks like he's a goner."

"The swine. They'll pay for this — hard covers are a violation of the Geneva convention." *He is interrupted by a fearsome sound coming from the rear.*

"Listen men — do you hear that? That's our own batteries starting up. Now we'll give them a taste of their own medicine." *The Whump, Whump, Whump of the NORML heavy artillery is terrifying and the men cower in the trench as lethal copies of the LeDain report, the Jamaican study, and the 6th Annual Report to Congress from HEW go winging overhead.*

"That will blast a gaping hole in their defenses men. Now, just before we go over the top I'd like to read you a few inspirational words from II Samuel, Chapter 21, selected for this occasion by our chaplain, Canon Walter Dennis: Then Sibbechai the Hushathite slew Saph, which was of the sons of the giant and there was again a battle in Gob with the Philistines, where Elhanan the son of Jaareoregrim, a Bethlehemite, slew the brother of Goliath the Gittite, the staff of whose spear was . . . . Billings, stop that giggling this instant. I said STOP IT. You too Wilkins. For God's sake men, let's get our act together, we're going over the top in . . . in . . . When did I say we were going over the top, corporal?"

"Like our barrage started at 1300 hours right. And you said that we were going to jump off at . . . at . . . Jesus Sarge, I can't remember."

"OK corporal — you ring up headquarters and have them give us the time again, and this time you'd better write it down. Meanwhile, I'll just read this inspirational thing written by former Attorney General Ramsay Clark: Give us legalization or give us death! O brave kamikazi of the cannabis brigade, yours is not to reason why, yours is but to do or . . . what's that corporal? Really? All right men: masks on, weapons at the ready, the moment of truth has arrived!" *Shrieking a blood-curdling war cry like Achilles on the plain of Troy, Sergeant York vaults over the sandbags and plunges into the shell-pocked landscape of no-man's land. Two minutes later he crawls back and peers down into the trench.*

"Come on men. Move out. I said MOVE OUT."

"Uh look Sarge, we don't know if this is really our thing."

"Come on cannabis comrades. This is where we make the big breakthrough. You want some other platoon getting its picture in *Newsweek* raising our glorious tri-leaf banner over their smoking lines . . . now what's so funny? I said WHAT'S SO FUNNY?"

"Like that's sort of a pun Sarge. See like we know you meant 'smoking lines' in the sense that their lines will be destroyed by our valiant charge. But when you think about it . . . hee . . . hee . . . , it's really our lines that are the smoking lines, you get it?"

"COME ON MEN. This is no time for stupid word games. The fate of western civilization lies heavy on your shoulders. Now I want every man-jack among you up and out of that trench before I finish counting. Ten . . . nine . . . eight . . . seven . . . what is it now Wilkins?"

"Gee Sarge, why don't we just stay here and listen to some music on the tape deck or something?"

"Come on men, get motivated. I SAID GET MOTIVATED. If you're not out of there by the count of five I'll court martial the lot of you, you cowardly cringing scum! I mean it! Stop that giggling. I said STOP IT! I SAID . . . huh . . . hee . . . hee . . . I get it . . . our lines are the smoking lines, right? Yeah, I get it! Corporal, you'd better check on that time again, 'cause I can't see that any of the other platoons have moved out yet. You do that corporal, and move those speakers out so we get a better stereo effect. Yeah . . . that's better . . . ."

Heroin plan addicts are flooding BC courts

By Tim Padmore

VANCOUVER — A flood of drug addicts being committed to British Columbia's compulsory heroin treatment program is threatening to choke the province's Supreme Court.

Officials estimate the 25-judge court will have to deal with 500 applications for committal in the last six months of this year.

Adding that many cases to an already crowded docket will definitely cause problems, Chief Justice Allan McEachern told **The Journal.** Civil cases now routinely take up to three years to move through the court.

He said a few of the addict cases will be given priority to help establish precedents, but it hasn't been decided how to deal with the others.

Under the province's heroin treatment act, people judged to be addicted and in need of treatment are invited to commit themselves to the three-year treatment program. If they decline, the issue goes directly to the Supreme Court.

The cases promise to be complex ones involving expert testimony on both sides to establish medical facts and to determine both the need for treatment and the likelihood that treatment will help, said Warren Standerwick, a member of the BC Bar Association's committee on the heroin plan.

"It makes me think that when they write legislation they should have judicial impact studies, like environmental impact studies when they dig a mine."

Alcohol and Drug Commission chairman Bert Hoskin confirmed the estimate of 500 Supreme Court applications in 1979. The commission expects, he added, to win 80% of them.

He said an attempt will be made to smooth the flow of addicts and police will cooperate by not referring addicts if the system becomes clogged.

He suggested a special drug court may be set up. But attorney general Garde Gardom later said it is premature to talk about a special court, while promising that any problems "will be adequately taken care of."

Mr Hoskin, asked if lengthy court delays might compromise the program's therapeutic objectives, said: "We didn't write the legislation (but) we have to live with it."

* * *

Meanwhile, BC's minister of human resources has refused to allow the heroin plan to set up an addict evaluation centre in a building housing a youth counselling service run by her ministry.

After a meeting with upset neighbors and parents, Grace McCarthy said she will see that the heroin plan, which comes under the health ministry, finds another location.

* * *

The final budget for the heroin program is $8.7 million in 1979, just over half the $15 to $16 million BC's health ministry planned to spend originally.

Of that, $3.1 million will go to the 150-bed locked door treatment centre on Vancouver Island. That facility will also get 156 of the total 363 staff to be hired.

* * *

The heroin plan now has its own director, psychologist Jack L. Altman.

Dr Altman, currently a visiting professor at the University of Quebec in Montreal, starts his duties in May.

Debate rages on rights, BC plan

Tim Padmore, Vancouver correspondent for **The Journal**, *was chairman of a panel discussion on British Columbia's controversial plan for compulsory treatment of heroin addicts at a recent international conference here sponsored by the American Society of Law and Medicine. Mr Padmore writes:*

VANCOUVER — Ethical principles, law, and health were the weapons in a clash between factions for and against British Columbia's compulsory heroin treatment plan at an international conference held here.

The conference wound up with a panel on the controversial heroin legislation.

The law, said Warren Standerwick of the BC Bar Association, violates a guarantee in the Bill of Rights that a person's liberty can be taken away only by due process of law.

Barry Sullivan, counsel to the Alcohol and Drug Commission, (ADC) which administers the heroin plan, said the Bill of Rights only applies to federal legislation so "we can put the Bill of Rights out of consideration."

Mr Standerwick acknowledged the legal point and retorted, "So what?"

Ken Varnam, chairman of the BC Medical Association's drug and alcohol committee, noted that long term heroin use in itself causes few medical problems — he listed decreased sexual drive and infertility and a hazard of prematurity to unborn babies — but said other medical complications like hepatitis, abscesses, and blood clots are the result of legal and social sanctions against heroin use.

John Russell, an ADC commissioner, said Dr Varnam seemed to be advocating free heroin and cited British statistics which he said indicate a worsening of the drug problem when heroin was made legally available to some addicts.

Dr Varnam denied that he advocates legalized heroin, but said he considers the BC approach inhumane. He said new research indicating that drug addicts may suffer from a deficiency of endorphin, a class of endogenous brain opiates, suggests a potentially better approach to treatment.

It's not clear that present treatments do much at all, he said, especially when it's remembered that 50% of drug addicts spontaneously stop taking drugs by the time they're 35 years of age.

Sicker smokers

LONDON — Cigarette smoking has taken another serious knock in Britain with the publication of a report suggesting smokers suffer many more "minor ailments" — from migraine to aching feet — than non smokers.

The claim might not persuade victims of the weed to change their ways overnight. But since the report pointed out that sickness absence, largely from minor ailments, costs Britain 320 million working days annually, it is likely to produce a wave of enthusiasm for anti-smoking propaganda among employers.

This latest indictment of the smoking habit was based on the results of a questionnaire completed by 1,615 office workers of whom 19% were male and 1% female, 57% single and 36% married. The complete age breakdown was as follows:

AGE	%
Under 18	9
18 - 20	23
21 - 23	23
24 - 30	25
31 - 40	12
41 - 55	7
56 and over	1

The report's authors discovered that nearly half the sample did not smoke (45% with 10% admitting they were ex-smokers and one in 20 stating they had given up the habit in the previous 12 months).

The comparison of smokers with non smokers in terms of frequency of sickness was as follows:

AILMENTS	FREQUENT OCCURRENCE %	SMOKERS %	NON SMOKERS %
Headaches	17	59	41
Period pains	14	55	45
Eye fatigue	9	65	35
Run down	8	79	21
Pains in the arms/neck/back	8	68	32
Aching feet	8	64	36
Hay fever	8	38	62
Cold	7	62	38
Stress/worry	7	77	23
Stomach pains	6	73	27
Migraine	6	61	39
Indigestion	4	65	35
Influenza	3	67	33
Heartburn	3	83	17
Earache	2	70	30
Toothache	2	64	36
Heart trouble	2	79	21

The report says: "Ailment such as colds, migraine, toothache, heartburn, and indigestion all appeared to be suffered more frequently by smokers than by non smokers. Only hay fever and menstrual pains do not fit into this category."

The profile of smokers within the sample was as follows:

Do you smoke?	%
Not at all	45
Up to 5 a day	7
6 - 10 a day	10
11 - 20 a day	22
21 - 30 a day	10
31 - 40 a day	4
More than 40 a day	2

Taking the Pulse, An investigation into the health of Secretaries and Other Staff. Alfred Marks Bureau 8 - 9, Frith Street, Soho Square, London W1V 6AJ Tel: 01 437-7855.

GENEVA REPORTS

'First class' smuggling

GENEVA — Smuggling drugs in first class letters around the world is on the increase.

For police, it's a major problem. For the smugglers, it's "very profitable," according to the man in charge of the Royal Canadian Mounted Police (RCMP) drug enforcement branch.

"A single first class letter averages between two and four grams of 85%to 95% pure heroin. When diluted and sold at the street level price, this heroin would net the traffickers a profit of from $16,000 to $29,000 for each letter."

This method of distributing drugs is "increasing and represents a major problem for enforcement personnel to cope with," Superintendent Y. E. J. Beaulieu told the 28th session here of the United Nations Commission on Narcotic Drugs.

He said a variety of illicit drugs is entering Canada in this way.

Supt Beaulieu also told the commission that the involvement of traditional criminal organizations, national and international, is on the increase in both the importation and distribution of cannabis in Canada.

"Secluded areas on our eastern and western coastlines have been used as drop sites for multi-ton shipments of cannabis into Canada.

"Also, we have noticed a significant increase in the utilization of sea-going pleasure craft to smuggle this contraband from source countries into Canada."

He said "cannabis abuse remains the most prevalent drug problem in Canada" and Mexico and Colombia are the main source countries for the drug.

"Colombian marijuana began to dominate the illicit market throughout Canada in the third or fourth quarters of 1978. This trend surfaced during the latter part of the second quarter of the year as reports of marijuana originating from Mexico contaminated with the herbicide Paraquat surfaced."

Source countries for hashish and hashish oil remain India, Nepal, Pakistan, Morocco, and Afghanistan although there has been an increase in hashish shipments from Lebanon and the RCMP anticipate an increase in drug activity between Lebanon and Canada this year, he said.

Psychotropics watched as narcotics use reduced

GENEVA — Even if supplies of narcotic drugs are markedly reduced, there is a dangerous possibility that psychotropic drugs will replace them, George Ling, the director of the United Nations Division of Narcotic Drugs, has warned.

"Indeed, in parts of North America, the reduced availability of illicit opiates appears to have resulted in an upsurge of the illicit manufacture, distribution, and abuse of such substances as phencyclidine," he told the 28th session here of the UN Commission on Narcotic Drugs.

He suggested a large part of the problem "will be overcome when more countries adhere to the requirements of the 1971 Convention on Psychotropic Substances."

And he urged countries which have not yet done so, to ratify the Convention "with the least possible delay."

While rational and intelligent use of psychotropic substances can produce rewarding therapeutic benefits in people "we also know that the illicit and indiscriminate use of psychoactive drugs can be associated with

George Ling

patho-physiological and psycho-social problems.

"We must make a concerted effort to reduce the increasing demand for psychotropic substances and, at the same time, take measures which will decrease their availability whether they are illegally manufactured in clandestine laboratories or diverted from licit channels."

He said this "disturbing trend," as well as increasing multiple use of stimulants and depressants in combination, both in developed and developing countries, "makes it clear that it is not sufficient only to become Parties to the treaties but more importantly, it is mandatory that the requirement of these treaties be fully implemented with the full participation of all concerned agencies within national governments."

Glamorous images of non smokers could go a long way, baby

By Pat McCarthy

AUCKLAND, NZ — Instead of trying to attack the image perpetuated by cigarette promoters, non smoking campaigns should replace it by creating a positive image or myth for the non smoker.

In doing so, stop smoking campaigns have much to learn from the tobacco industry, Garry Egger told the 49th congress of the Australian and New Zealand Association for the Advancement of Science here.

"Cigarette advertising has performed the miracle of transforming a smelly, irritating, combustionable object which kills 8,000 to 10,000 Australians a year, reduces sexual potency, creates halitosis, and causes coughing, wheezing, and other discomforts, into a magic potion which turns its user into a dashing, suave-clad horseman, a clever daring little trickster, a naked bather under a crystal clear waterfall, or a popular seducer of beautiful ladies."

Dr Egger, a research scientist with the Health Commission of New South Wales, Australia, said anthropologists see much modern advertising as fulfilling the function of myths in traditional societies.

Like myths, advertising acts as an anxiety-reducing mechanism — first by restating essential dilemmas of the human condition, then by offering a solution to them. The action of the myth remains strong even if rational explanations later belie it. In traditional societies, hero and initiation myths appeal to the sub-mature ego, and transcendent myths appeal to the more mature ego.

A potent version of the hero is the "trickster" myth. Subtle, fun-loving, defiant, unthreatened, and uncomplicated, the trickster has particular appeal to the sub-adolescent. He is identifiable with the average person, yet can compete with the super-human and invariably win.

Dr Egger said Australia's best-selling cigarette brand, Winfield, is promoted by the trickster image of entertainer Paul Hogan.

Since the trickster is, by definition, beyond reproach, any health appeal aimed at attacking him is doomed to failure. The health appeal, with its delayed gratification (ie postponement of premature death perhaps 40 years hence) and its incitement to those identity-seeking young wishing to show strength by defying the odds, must suffer the fate of Goliath in the hands of David.

Dr Egger said it should be obvious that rational, information-based appeals aimed at preventing smoking among adolescents will not work. Youth have limited time perspective and experimentation with tobacco is so common — "one might suggest it is a necessary psychological state in maturation" — that encouraging them not to smoke might be less productive than decreasing the appeal of continued smoking. "This approach has the added appeal of making the non smoker one who has 'been through all that' and moved to a higher plain."

For today's youth, motivation comes from sex, sport, physical attraction, and peer acceptance — although not necessarily in that order, he said.

"The appeals of non smoking, therefore, are appeals to increased sex appeal (improved breath, better performance) and improved physical performance. As the mythical hero figure has a logo (motif, symbol, sign) as identification, so should the new non smoking anti-hero, whether this be in the form of a hand signal, message, slogan, or catch-phrase."

Dr Eggers said a mass media campaign employing the creation of an image around the non smoker is being drawn up for pilot testing in an area of New South Wales.

Boosting the non smoker's image . . . a campaign sticker from New Zealand

'It's good to go it alone,' says AA, NA grad

By Harvey McConnell

SAN FRANCISCO — Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous are the vital first step in giving up alcohol and drugs, but one person who has been there thinks they can act as an impediment as well.

This is the experience of Millicent Buxton, who is currently involved in programs for non-medical approaches to the treatment of addictive diseases for the Haight-Ashbury Treatment and Education Projects here.

It is her experiences over two years as a member of both AA and NA that Ms Buxton is trying to communicate to health professionals and others (**The Journal**, June, 1978.)

She told **The Journal** she does not want to diminish the importance of NA and AA, but people should be aware the two organizations are not the final solution for many abusers.

Her introductions to the organizations "really allowed me to see that, in fact, you could live without the use of chemicals. They gave me a base, an equilibrium.

"When I saw people in the groups initially, I just couldn't believe that they were chemical free. It was amazing to me because it was always a fantasy of mine, but I could never do it. I didn't have the remotest idea how to do it.

"There was also a sense of community, and belonging, and dealing with the alienation I had felt, and I started getting better and stronger in my life."

After a time, however, Ms Buxton felt she was being stifled as an individual with the constant pressure of group thinking.

"I really began to feel I was being smothered and, in a certain sense, being brainwashed. There was the constant message: 'You can't do it alone, you cannot live a life with a chemical free philosophy by yourself, you need us.' I began to feel this is not how I wanted to live my life," Ms Buxton added.

The constant repetition of "my story" made her feel she was always dwelling in the past "and I didn't think this was very healthy. If you are trying to build a present and future, how can you live in the past?"

Ms Buxton adds: "It is very important to have your sobriety as everything else in your life is contingent on that. But just to be clean and sober isn't enough.

"I found there was not a great deal of emphasis on improving your psychological situation. As long as you are sober and clean everything else you do is OK. You can be as big a screwup in the world as possible, as long as you are clean. However, I think you have to do other things in your life."

Ms Buxton became so depressed by her experiences she decided to leave AA and NA. She adds:

"I was very frightened at leaving, because they had always told me that if I left I would start using and drinking, and I wasn't sure that that would not happen. But I felt I needed to take the risks and make changes in my life."

Now, 18 months later, Ms Buxton is fine. She attends therapy once a week and is an avid runner, covering some seven miles or more a day up and down the hills of San Francisco.

Ms Buxton in the training sessions and programs gives the message "while it is fine to say go to AA or NA, you should also know something about the groups themselves. We support the self-help group, but we want people to realize you can go beyond them.

"We try to explain, as well, that there are limitations within the medical system for the treatment of addictive diseases. Often the system perpetuates it. Many medical practitioners, for example, are not aware of what addiction means and may prescribe codeine to someone and start them off on a run instead of looking for non-pharmacological means to deal with the pain."

Millicent Buxton: Self-help grou not the final step.

High fever comas seen in PCP case

NEW YORK — Angel dust can potentially cause death by producing malignant hyperthermia — rapidly elevating temperature progressing through coma to death.

So suggests Kung-ming Jan in a letter to the editor of *The New England Journal of Medicine*.

Angel dust is a street name for phencyclidine, a drug introduced to clinical trials as an anesthetic, in 1957.

It is also known as PCP, Peace, Horse tranquillizer, or Hog, and was discontinued for indications in humans because it produced amnesia, analgesia, rigid muscles, delirium, and acute psychotic reactions.

It is widely used by veterinarians, however, as a short term immobilizing agent for surgical procedures.

As a powder, it may be mixed with dried parlsley or marijuana and smoked. It may also be present in material held to be LSD, mescaline, psilocybin, tetrahydrocannabinol, and other psychedelics and amphetamine-like compounds.

Dr Jan's letter was an attempt to call the possible side effect of gross temperature increase to the attention of those who may have to deal with cases of phencyclidine abuse. He says moderate temperature elevation from use of the drug is not uncommon. Malignant hyperthermia as a result of such abuse is more rare.

He reported the case of a 24-year-old male who arrived unconscious at Louisville General Hospital with hyperthermia and coma. It was established the patient had taken phencyclidine with alcohol about four hours before admission.

The patient's pupils were dilated and temperature in the esophagus was 108F. Routine cultures and chest x-ray showed no known fever-causing agents.

The man's coma deepened further and intubation with mechanical breathing apparatus was required to maintain a patent airway.

Treatment was by ice packs and cooling and the patient was discharged 48 hours later.

SMOKE-FREE DINING

The British Columbia Medical Association is awarding framed certificates to restaurants that set aside non smoking areas.

"Nobody likes to breathe other people's tobacco smoke, and we think that restaurants which are forward looking in responding to the public demand by designating areas where smoking is not allowed deserve recognition," said Dr Bob Young, chairman of the association's communications committee.

Alcoholism an inherited disorder?

TORONTO — There is growing evidence that alcoholism is an inherited disorder although psychiatric bias to date has leaned toward "a psychosocial explanation for almost everything."

Richard Swinson, staff psychiatrist, Toronto General Hospital, conceded that alcoholism is environmentally influenced. However, he told an audience at the Addiction Research Foundation of Ontario here, the disease can be inherited.

"In men it appears to be genetically influenced, but the picture for females is not so clear," Dr Swinson said.

Dr Swinson has done his own research on genetic factors in alcoholism, and has just completed a major review of the literature on the subject.

A recent study of adopted children in Denmark found that 30% to 40% of adopted male children whose natural parents were alcoholics became alcoholics themselves when they reached their 30s and 40s. But fewer than 1% of the children whose biological parents were not alcoholics suffered from alcoholism in later life.

The same study, which looked at female offspring, was less conclusive. Dr Swinson, added, however, there is some evidence women can also inherit the problem.

"What they did find was when these groups drank, there was a statistically significant increase in the rate of which the adopted females reported amnesia after drinking, although there were no other drinking problems that were identified.

"And the suggestion is that perhaps there is more environmental influence on the development of alcoholism amongst women than there is amongst men."

In another study, when compared with a control group, there was an increase in the rates of depression among adopted women, but a much greater increase in the occurrence of depression among non adopted female children of alcoholics.

Dr Swinson added that studies on the subject have not pointed to a definite genetic marker for alcoholism.

US drug problem– from bad to worse

GENEVA — The United States drug problem is moving from "an acute to a chronic situation," Jean Paul Smith told the 28th session of the United Nations Commission on Narcotic Drugs.

And experimentation with drugs is continuing to increase, said Mr Smith, assistant director for international activities, US National Institute on Drug Abuse.

While the "heroin epidemic" has subsided, he said, abuse of cocaine has increased sharply, prescription drug misuse has increased moderately, and experimentation with drugs, especially marijuana, has increased.

Overall rates of psychoactive drug consumption "remain high, transcending racial, cultural, social, and economic lines, and involving millions of people using hundreds of substances."

He allowed that daily use of controlled drugs, except marijuana, remains confined to less than one per cent of the population. However, he said: "Excluding the misuse of prescription drugs, illicit sales, and the intangibles of psychological, social, and community suffering, we estimate that the approximate cost of the abuse of drugs, excluding alcohol, in the US, is in excess of $10 billion dollars per year."

Turning to treatment, he said more than $500 million dollars were spent on drug treatment in the US in 1978, with the largest single source of funding being state governments.

"The most important question about treatment is: does it work? Extensive studies of treatment outcome show clear and positive results: reduced drug use, increased employment, and less criminality for persons in drug free, therapeutic communities and methadone maintenance programs.

"Even if complete recovery or total abstinence from drug use is not achieved for every client, an overall reduction in drug use with improvement in related measures clearly demonstrates the contribution of treatment and rehabilitation to a national drug abuse program."

Jean Paul Smith

RCMP outlines direction drug traffic will take

GENEVA — Canadian trends in drug traffic for this year, as anticipated by law enforcement officials, were set out at the 28th session here of United Nations Commission on Narcotic Drugs.

Superintendent Y. E. J. Beaulieu, head of the Royal Canadian Mounted Police (RCMP) drug enforcement branch, said the RCMP expect:

- Multiple drug abuse will remain the predominant mode of drug taking.
- Heroin will fluctuate in availability, with Southeast Asia continuing to supply upwards of 90% of the domestic market.
- There'll be a gradual increase in the abuse of cocaine.
- There'll be an increase in the number of clandestine laboratories producing methamphetamine, phencyclidine (PCP), and other psychotropic drugs.
- Widespread abuse of the cannabis derivatives will continue.
- There'll be an increase in the abuse of pharmaceutical drugs diverted from the legal market, especially the tranquillizers and the amphetamine group.
- Abuse of the hallucinogens will continue to fluctuate; abuse limited primarily to young drug abusers.

Y. E. J. Beaulieu

GILBERT

'Heavy drinkers might not drink so much if they were less inclined to drink at home . . .'

By Richard Gilbert

Public and private drinking

The table below illustrates the three great trends in post-war alcohol use in Ontario:
(1) we have come to use much more alcohol (although not very much more since 1974);
(2) we have moved from being mainly a beer-drinking society to one in which more alcohol is drunk in the form of wines and spirits;
(3) our drinking has become more private — private in the sense that it happens in people's homes rather than in bars, restaurants, or taverns.

Researchers and policymakers have agonized over the first trend, noted the second, and overlooked the third altogether. As a result, gathering data for a column on public and private drinking was a major undertaking. It's a pity the pattern was not put together before. The increase in private drinking may be the most significant trend of all.

What has been termed the alcoholization of our society has often been attributed to the progressive loosening of drinking laws since 1948, when we were permitted to drink wines and spirits in public places for the first time since 1916. The facts in the table indicate the opposite. While overall per capita alcohol consumption increased by 52% during the last 25 years, public consumption *declined* by 18%. Private consumption, meanwhile, increased by a staggering 90%. The alcoholization of society has occurred in our homes.

The figures in the table are based on sales. The trend to private drinking is even stronger than the table suggests, on account of the popularity of home-made wine. In the part of Toronto that I represent on City Council, some 50 to 100 gallons of wine are made each year in every other home, amounting to an annual per-capita consumption of about 400 drinks from this source alone.

Cause of excess

The correlated trends of increased drinking and private drinking suggest that one may be causing the other. Has alcohol consumption gone up because we are becoming a private society and doing more of our drinking at home?

The correlation between increased drinking and private drinking survives closer inspection. The sharpest ever increase in alcohol use occurred between 1945 and 1948, when consumption of wines and spirits in public was forbidden. Since 1974, when per capita alcohol use has been virtually unchanged, the amount of private drinking has also remained stable, at close to 81% of all alcohol use. (The decline in beer consumption in public has continued during the past five years, but it has been neatly countered by an equivalent increase in the public use of wine and spirits, particularly wine.)

A correlation is never conclusive evidence of cause. Nevertheless, it is tempting to speculate that the best way to reduce overall consumption might be to try to reduce private drinking.

Apart from the correlation, there are other reasons for supposing that private drinking might be less restrained than public drinking. Private drinking is more likely to be solitary, or with companions inured to excess. Public drinking occurs under more watchful eyes. The results of a recent survey of drinking in the Durham region, east of Toronto, suggest that heavy drinkers do more of their drinking at home than "social" drinkers. Heavy drinkers might not drink so much if they were less inclined to drink at home.

The proportion of private drinking could be reduced by increasing its cost, and reducing that of public drinking. Currently public drinking costs three times as much as private drinking. Perhaps the cost of each could be made similar, by doubling the cost of private drinking, and reducing the cost of public drinking by one third, effectively raising the overall cost of alcohol by about 90%.

A large overall increase in alcohol prices might be much more acceptable if there were a simultaneous decline in the cost of drinking in bars, restaurants, and taverns.

Narcissistic focus

Any large increase in the price of alcohol would reduce overall alcohol use. Promoting public drinking, while limiting private drinking, could reduce public drinking further, and make the increase more palatable. A benefit of boosting public drinking might be an increase in the amount of and quality of our public life, and a reversal of the trend in our culture towards a narcissism that leaves no one to fend for society. This focus on self, and our disposition to live in smaller and smaller households, may together help cause the widespread loneliness that many regard as the chief curse of our age.

The costs of more public drinking might be an increase in public drunkenness, which in itself is not necessarily a problem, and more alcohol-related auto accidents. Promotion of public drinking would have to go hand-in-hand with tougher measures against drinking and driving, which would in any case be desirable. Our present tolerance of this criminal behavior is truly astonishing.

Promoting public drinking might be worthwhile even if reducing overall alcohol use were not the main objective. It would at least provide employment. Ten years of thinking about the costs and benefits of alcohol use have led me to the conclusion that many different levels and patterns of alcohol use in our society could be considered acceptable, save total sobriety and universal excess. A public debate on our alcohol use is long overdue. I hope to elaborate on these thoughts in a later column.

Change in drinking patterns in Ontario, 1953-1978, in drinks* per person aged » 15 yrs

Year	Total drinks per person	Beer		Wine & Spirits		All beverages	
		at home	out	at home	out	at home	out
1953	470	160	155	145	10	305	165
1978	715	255	90	325	45	580	135
Difference	245	95	— 65	180	35	275	— 30

*A drink is 12 oz beer, or 5 oz wine, or 3½ oz sherry or 1 oz spirits, each of which contains close to 13 grams of pure alcohol.

Next month: Caffeine and pregnancy

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Pot brain damage alarm unfounded

I would like to comment on the article Marijuana damages brain: Doorenbos (**The Journal**, Feb).

In addition to this alarming title, the article reports the shocking statement that marijuana is "the most dangerous street drug in America". Both of these statements are presented in such an assertive manner as to leave no question of their validity. However, there is no clear evidence provided for either of these claims.

The startling title is considerably diluted in the first sentence of the article which reads "Marijuana PROBABLY causes brain damage . . . ." Dr Doorenbos then seems to choose his words carefully to support his claim in the absence of substantiation. For example: "Many researchers BELIEVE marijuana CAN cause brain damage, and it is my FEELING it does."

He then goes on to describe some of the symptoms of a marijuana high, none of which constitutes evidence for the drug damaging the brain. He then presents a reported long term effect which is based on correlational data at best and is confounded by so many social/psychological factors that it provides no evidence for his claims.

Admittedly, it would be cumbersome and impractical for **The Journal** to expect or provide extensive substantiation for all claims made in it. However, with a topic as controversial and politically imminent as the marijuana question, there is a responsibility of scientists to support claims they make to the media and a responsibility of the media to discriminate between scientific evidence and unfounded opinion. **The Journal** has traditionally honored its professional responsibility to the readers in this respect, and it is this reputation that I hope to maintain by pointing out this isolated oversight.

Mike DeVillaer
Community Consultant
Hamilton
Addiction Research
Foundation of Ontario

Why the 'quixotic' logic?

Richard Gilbert's logic is difficult to follow. In his article on second-hand smoke (**The Journal**, Feb), both the headline and the featured quote imply one thing but the article, if you read to the end, draws another conclusion.

Why does Dr Gilbert emphasize "facts" based on incomplete knowledge only to admit that later studies show something else? As he himself says (but only in the sixth paragraph), the facts have changed. Evidence, indirect or otherwise, is evidence. And the evidence is that tobacco smoke contains potent carcinogens, among other undesirable and unhealthy compounds.

To say that "nevertheless, campaigns against public smoking do not get much support from the data on passive smoking and physical health" is an unsubstantiated and probably unsubstantiable assertion.

Dr Gilbert goes on to recognize that "the unpleasantness and unpopularity of tobacco smoke are established beyond question." Good. But why the quixotic refusal to concede, more importantly, the foreseeable hazards to health?

As a chemist, I would rather warn people of the likely hazards than to dwell on the absence of absolute certainty. There are, after all, very few things in life which are absolutely certain. And one does not have to be "a militant anti-smoker" to regret that the Addiction Research Foundation of Ontario condones Dr Gilbert's attitude and questionable logic.

(Dr) M. S. Gibson
Professor of Chemistry
Brock University
St Catherines, Ont

Editor's Note: While **The Journal** *is published by the Addiction Research Foundation, the publication's mandate is to report issues and events of importance to, and to reflect the wide range of opinion in, the alcohol and drug field as a whole. Decisions relating to editorial content are the editor's.*

Nabilone remedy may be worse than disease

NORML (The National Organization for the Reform of Marijuana Laws) is watching with great interest the emergence of Nabilone as a possible therapeutic agent (**The Journal**, Nov, 1978 — Marijuana Option Tests Continue).

It has long been our contention that marijuana has therapeutic properties which should be fully developed. Our concern lies with those who have needlessly suffered since 1970 when marijuana's ophthalmic and anti-emetic effects were first reported. To deny cancer and glaucomic patients access to marijuana because of the "euphoria" associated with the drug seems ridiculous when one considers the disphoric effects of the legal drugs now available to these people.

Even more disturbing is the confusion regarding Nabilone. You state that Nabilone causes "no euphoria, dry mouth, lowered blood pressure, increased pulse rate." Yet the September 29th issue of JAMA *(The Journal of the American Medical Association)* clearly disputes these claims. Researchers seem particularly concerned about blood pressure changes. And according to information presented at a recent meeting of the Interagency Committee on New Therapy for Pain and Discomfort, Eli Lilly has suspended Nabilone research projects because of reports of disturbing consequences from long term use of the drug.

Finally, but certainly not least of all, is concern regarding Nabilone's potential for abuse. Any drug is abusable but the organic form of marijuana is among the most benign of all recreational drugs. Nabilone has already been heralded as "The Tranquillizer for the New Age" and some have noted that it may well be the "new Valium."

Nabilone will certainly have advantages, but will the remedy prove worse than the disease?

Alice O'Leary, Coordinator
Medical Reclassification Project
NORML
Washington, DC

The Journal Special Report

THE BREWERS/ARF FILE

In June, 1978, **The Journal** published the entire text of an Addiction Research Foundation of Ontario document entitled, A Strategy for the Prevention of Alcohol Problems. A letter dated Nov 6, 1978 to Dr John Macdonald, president of the Foundation from Mr Kenneth Lavery, president of the Brewers Association of Canada, was accompanied by a critique prepared by the Brewers of Ontario entitled, Ontario Deserves Something Better from the Addiction Research Foundation. The Foundation responded in writing in Feb 1979 and was scheduled to meet with the representatives of the Brewers and the Minister of Health for Ontario on March 8, 1979.

As a contribution to understanding the debate, **The Journal** presents here the full text of the Brewers' critique and the Foundation's response.

Opening Correspondence

Nov 6, 1978

Dr John B. Macdonald
President
Addiction Research Foundation

Dear Dr Macdonald:

Attached is a copy of a critique of your Strategy Paper dated Feb 17, 1978, which was prepared recently by the Ontario brewers.

The brewing industry has some serious and fundamental criticisms of the paper. When a representative of the industry was invited to participate in the recent conference held by the School For Addiction Studies of your organization, having as its opening event An Examination of the Preventive Strategy Proposal presented to the Provincial Government, we were delighted as we felt that this was the forum in which to discuss the matter.

The invitation was to address the meeting on Economic Issues Associated With Implementation. However, because of the industry's concern with the Strategy Paper on which the discussions were to be based, we communicated this concern to Mr Schankula* and requested that we be allowed to make a formal presentation with respect to the paper. This request was denied (see copy of our letter to Mr Schankula).

We were disappointed that we could not make a meaningful contribution to your seminar. However, the opinion was that this is too serious a matter to drop and subsequently, the Ontario brewers decided to take further action. Today, they made a presentation to a number of senior government Ministers and officials and distributed to them copies of the attached critique.

We wanted you to know what has taken place and why.

Yours very truly,

Kenneth R. Lavery
President
Brewers Association of Canada
Ottawa

(*Editor's note: Henry Schankula is director, Education Resources Division, ARF)

Nov 10, 1978

Mr Kenneth R. Lavery
President
Brewers Association of Canada

Dear Mr Lavery:

We have your letter of Nov 6 and accompanying criticism of the publication entitled, A Strategy for the Prevention of Alcohol Problems. In view of your strongly worded criticism it is unfortunate that you did not avail yourself of the invitation from the Foundation to participate in the recent Senior Management Seminar. I understand that Mr Schankula made it clear to you that there would be ample opportunity to criticize the "Strategy" document, both in discussion following the Popham-Schmidt presentation and throughout the meetings.

In any case it is now important for representatives of the Brewers Association to meet with representatives of the Foundation to review the basis of the original document and your critique. We will need a reasonable interval before meeting with you in order to re-examine the primary data against the criticisms you have made. I propose to contact you as soon as our review is completed.

Meanwhile, pending completion of our review I wish to deny in the strongest terms that any deliberate exaggeration of future trends was engaged in or that scare tactics rather than objective analyses were intended. The persons responsible for the preparation of the Strategy document are honorable men and ethical scientists of international repute. This is not to say that they are beyond making errors. No one is. Whether errors have been made, and if so their significance remains to be determined but the scientific integrity of those involved is beyond question.

Sincerely,

John B. Macdonald
President
Addiction Research Foundation

cc Hon D. Timbrell
Minister of Health
Toronto

Feb 23, 1979

Mr C. D. Muir
President
Brewers Warehousing Co Ltd.
Downsview, Ontario

Dear Mr Muir:

I enclose for your information our response to the criticism of the publication entitled, A Strategy for the Prevention of Alcohol Problems. The response was prepared by R. E. Popham, W. Schmidt, and H. Lau and deals only with those criticisms directed at our "Strategy" document.

Certain other criticisms were included in your document and our response to them follows:

1) You have claimed that the Addiction Research Foundation was not prepared to formally receive criticisms of the strategy paper from the Brewing industry. On the contrary, the Foundation issued Mr Lavery an invitation to attend and participate in a two-and-a-half day conference to examine the implications of the strategy proposal presented to the Provincial Government. He was advised specifically that he would be afforded ample opportunity to discuss the "Strategy" document following the Popham-Schmidt presentation and throughout the meeting.

2) You claimed that the Foundation employed "scare" tactics by providing the *Globe and Mail** with incorrect information concerning death from liver cirrhosis. The misinformation published in the *Globe and Mail* stated that 210,500 people died of liver cirrhosis in 1973.

The facts are that

a) On July 6, (a reporter from) the *Globe and Mail* requested statistics on liver cirrhosis over the telephone. These were provided and the same day the documents from which the statistics were drawn were delivered by taxi to (the reporter). No error existed in the documentation ("Statistics on Alcohol and Other Drug Use in Canada and Ontario: Data Available in 1976").

b) The offending article appeared in the *Globe and Mail* on Aug 22 (47 days after the information was provided).

c) The same day (Aug 22) the reporter was contacted. He acknowledged that the statistics for the "estimated number of alcoholics" were transposed with the statistics for "liver cirrhosis deaths". The reporter agreed to publish a full correction including all the data requested.

d) A correction, attributing the error to the Foundation and failing to include all the correct figures was published in the *Globe and Mail* on Aug 23.

e) On Aug 23 and 24, the *Globe and Mail* failed to respond to telephone messages left by our Media Relations Officer.

This record shows that contrary to the charges in the Brewer's critique, the Foundation went to considerable pains from the outset to ensure that the *Globe and Mail* reporter had accurate information.

Given the Ontario Brewers apparent commitment to accuracy, it is puzzling that no attempt was made to verify with the Foundation the *Globe and Mail*'s explanation of the error.

Sincerely,

John B. Macdonald
President
Addiction Research Foundation

(*Editor's note: The *Globe and Mail* is a Toronto newspaper.)

The Brewers

THE BREWERS
OF ONTARIO

Ontario Deserves Something Better From The Addiction Research Foundation

A critique of the Addiction Research Foundation of Ontario publication:
"A Strategy for the Prevention of Alcohol Problems: Background Information and Recommendations for the Parliamentary Debate on Control Measures"
Dated February 17, 1978

PREPARED BY
THE BREWERS OF ONTARIO
NOVEMBER 1978

CARLING O'KEEFE BREWERIES OF CANADA LIMITED ◻ DORAN'S NORTHERN BREWERIES INC. ◻ HENNINGER BREWERY (ONTARIO) LIMITED
LABATT'S LIMITED ◻ MOLSON'S BREWERY (ONTARIO) LIMITED ◻ BREWERS WAREHOUSING COMPANY LIMITED

A STATEMENT OF ERRORS AND OMISSIONS

On February 17, 1978, the Executive Committee of the Addiction Research Foundation of Ontario (ARF) released to every member of the Ontario parliament, all branches of the ARF, all Ontario radio and television stations, the Queen's Park Press, all Ontario newspapers and to the national press, a paper purporting to provide . . . *'background information on the problems of alcohol . . . together with an assessment of the role of control measures in the prevention of such problems and a recommended preventive strategy.'*

This document contains a substantial number of errors, uses incomplete data, and misrepresents recent and probable future trends of alcohol consumption in Ontario.

In spite of this condition, and the fact that the Ontario government had already announced its proposed changes in alcoholic beverage control measures on May 25, 1978, the ARF chose to give its own interpretation of the facts and needed policy changes even wider spread distribution by including its paper as a supplement to the estimated 10,000 subscribers of the Addiction Research Foundation Journal. In addition, the Foundation's newly-developed School for Addiction Studies planned as its opening event: "An Examination of the Preventive Strategy Proposal Presented to the Provincial Government," by the Executive Committee of the Foundation during a three-day seminar, October 23 to 25, 1978.

Under these circumstances, the brewers of Ontario feel obliged to bring to the attention of the government of Ontario both the inadequacy of the Addiction Research Foundation paper as an accurate and supposedly objective statement of alcoholic beverage trends in the province and particularly the misrepresentation it presents as to future *problems* which might arise.

As a publicly-funded alcohol research organization, the ARF should be able to provide the people of Ontario with scientific and objective information which will help to clarify rather than confuse the complex factors influencing alcohol use and misuse. This recent ARF publication, however, fails to do so, and is a discredit to the organization.

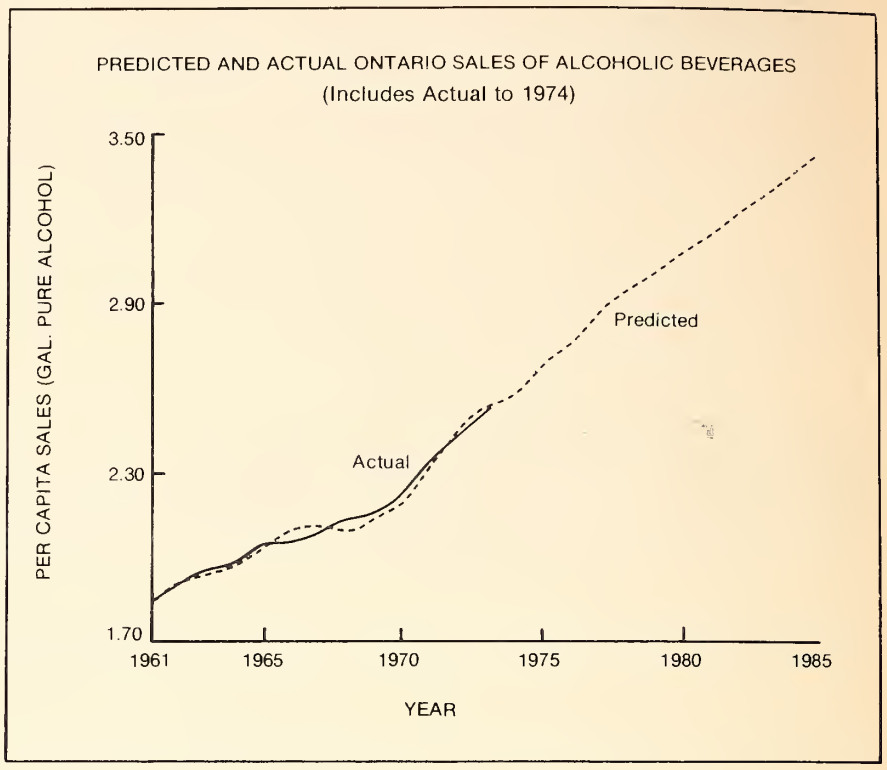
CURRENT AND FUTURE ALCOHOLIC BEVERAGE TRENDS MISREPRESENTED

Current and future alcoholic beverage trends are misrepresented, first in a graph *based on past trends and the best available indicators of future economic conditions*, and secondly, in a statement as to future sales based on *present rate of increase.*

Misrepresentation in Graph

An examination of the graph which appears in the Strategy Paper reveals that:
(a) Actual Ontario sales are shown only to the year 1974; and
(b) *Per capita sales* are in fact sales per adult 15 years and over, and thus overstate consumption by more than 30%.

An examination of the model (1) on which the graph was based further reveals that *the best available indicators of future economic conditions* were not used.

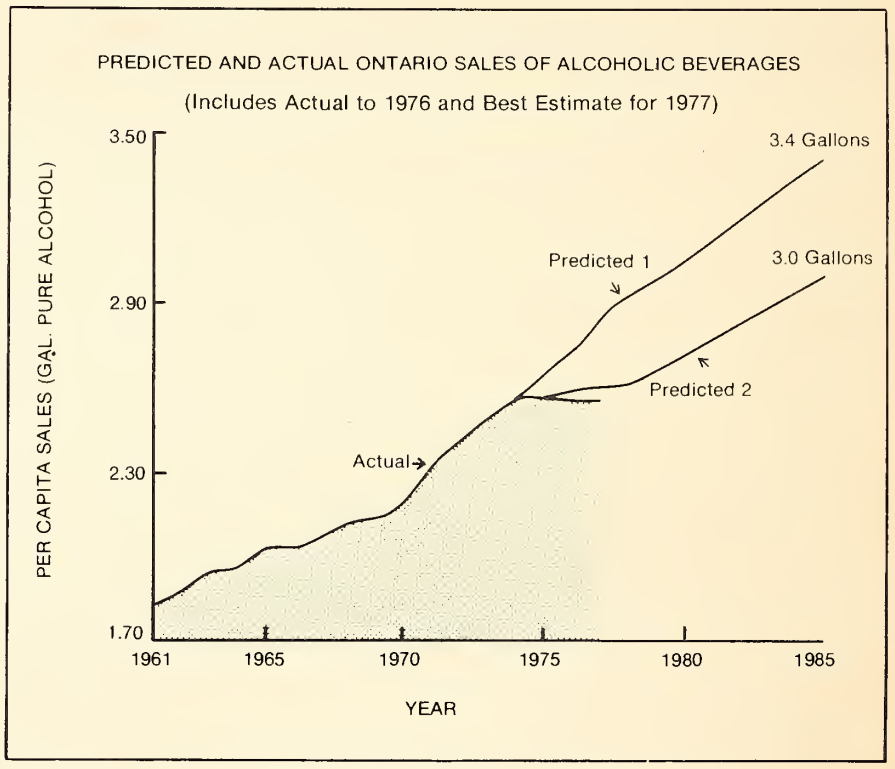


The ARF chose to use a model which was not based on up-to-date data; thus failed to take into account actual post-1974 conditions, with the result that the 1975 and 1976 predictions as to sales are greatly overstated, as well as the probable consumption in 1985.

At the time of release of the Strategy Paper in February, 1978, there were actual data available for at least two additional years. Appendix II sets out dates when more up-to-date data on the factors used in the model were available.

Had the above more up-to-date data been used, the graph up to 1976 would have appeared as shown below, whereby predicted and actual values for 1975 and 1976 would have shown the levelling off of consumption.

Further, even using the ARF predicted values for personal disposable income, Toronto and Ottawa price indexes and prices of alcoholic beverages (factors on which forecast consumption was based), the expected consumption in 1985 would have been substantially lower than that shown in the original graph (3.0 gallons per adult or an average annual increase of 1.5% after 1974, as compared with 3.4 gallons or an annual average increase of 2.6%).



Predicted 1 — Original ARF prediction made on basis of data to 1974.
Predicted 2 — Prediction had known current data been included, but original ARF future economic values still used, although unrealistic.

However, even the figure of 3.0 gallons we believe to be too high as, in the light of today's conditions, the forecasts used in developing the predicted sales no longer appear realistic. For example, the ARF model is forecasting that the consumer price index will rise through the years 1979 to 1985 by only 3.35% per year. No reliable forecasts which we have been able to find suggest that such a low rate of inflation will be achieved; even the Federal Department of Finance's Targets (2) are higher than 3.35%.

Another example is the price of beer, which the Foundation forecasted to rise at an annual rate of 2.4%. The past four years have shown an average annual rise in the area of 8%.

Misrepresentation in Statement

Then the paper goes on to say that the *expectation is that the present rate of increase will continue, and that by 1985 per capita sales in Ontario will be about 50% greater than in 1975* which means a consumption of 4.0 gallons as compared with the 3.4 gallons indicated by the graph. (3)

Although the paper was prepared in 1978, *present rate of increase* refers not to the immediate pre-1978 period, but is the rate of increase experienced in the 1970-1974 period. In actual fact, the present rate of increase is virtually nil. (4)

In Summary

Thus, in summary, by ignoring up-to-date data available at the time the Strategy Paper was issued, the current levelling off in consumption is not shown. In addition, predictions to 1985 are not substantiated, and are, in all probability, grossly in error.

Also, due to the use of an imprecise description of sales on the graph, the impression is left that consumption of alcoholic beverages in Ontario is 30% higher than it actually is.

If, by its own admission, the ARF researchers believe that: *From a standpoint of preventive strategies, it is crucial to consider what the future may hold in regard to trends in the sale of alcoholic beverages* . . . one must conclude that its proposed strategy and recommendations are founded on a gross misconception or a deliberate exaggeration of such future trends.

MISINFORMATION AND "SCARE" TACTICS

The seriousness of errors and exaggerations when presenting information relating to alcoholic beverages should not be underestimated. While professional alcohol researchers may catch such matters, others such as the press and the public may not. The result is the creation of a whole body of misunderstanding and mythology about alcohol use and misuse which makes the development and public acceptance of sensible alcoholic beverage policies very difficult indeed.

A recent example of how the press, using incorrect information, again emanating from the ARF, grossly exaggerated an alcohol-related health issue (in this case death from liver cirrhosis), is illustrated in Appendix III.

The reporter, having been provided with wrong figures from the ARF, created an article using such sensationalism as: *A plague strikes Windsor, kills entire population* . . . and stated that: *210,500 people (the size of Windsor)* . . . died of liver cirrhosis in 1973.

The gross error in the statistics on liver cirrhosis deaths quoted in the article (eg actual liver cirrhosis deaths in Ontario in 1973 were 1,002, not 210,500) was subsequently acknowledged (very briefly) by the newspaper carrying the original article, but we doubt that the false impression which this article created can so easily be corrected.

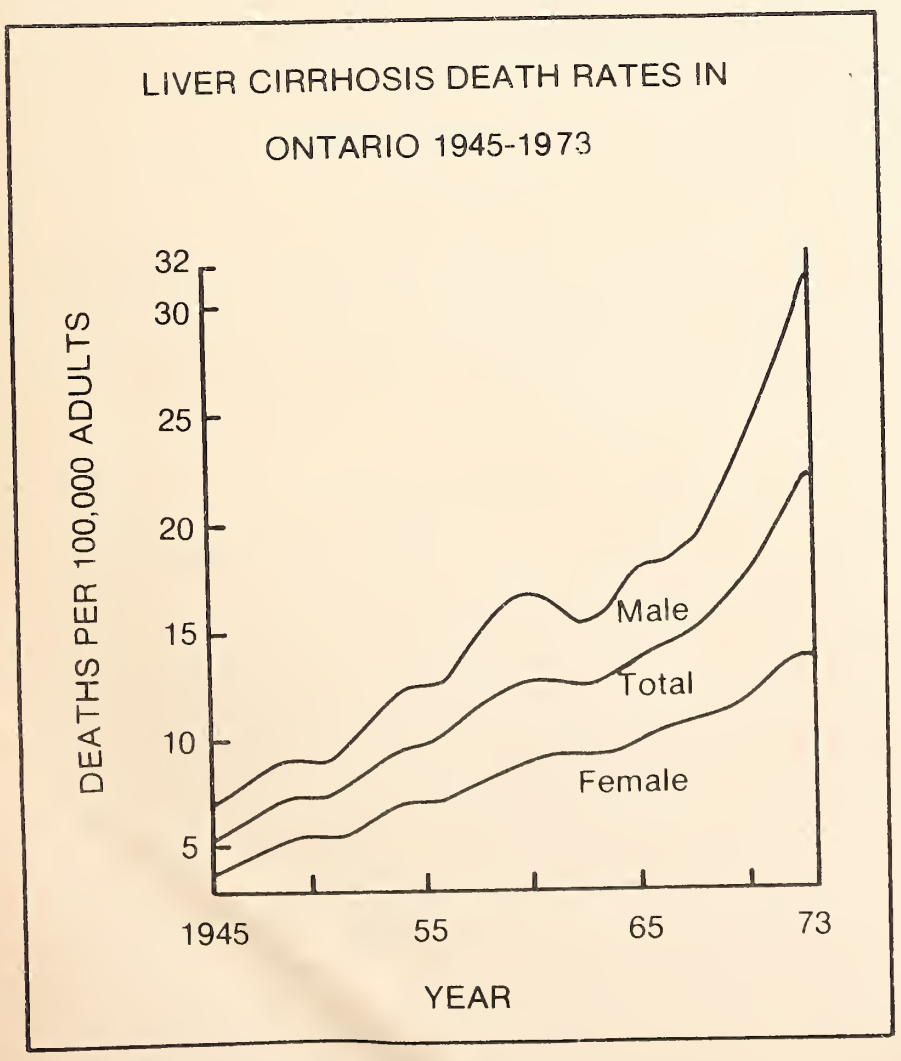
It appears to the brewers that the ARF in discussing the section on liver cirrhosis in its strategy paper, is using the same "scare" tactics.

Many investigators in the field of alcohol research (5) (except apparently within the ARF) do not agree that: *There is no better indication of the trend in the prevalence of alcohol-related health problems than changes in the rate of death from cirrhosis of the liver.*

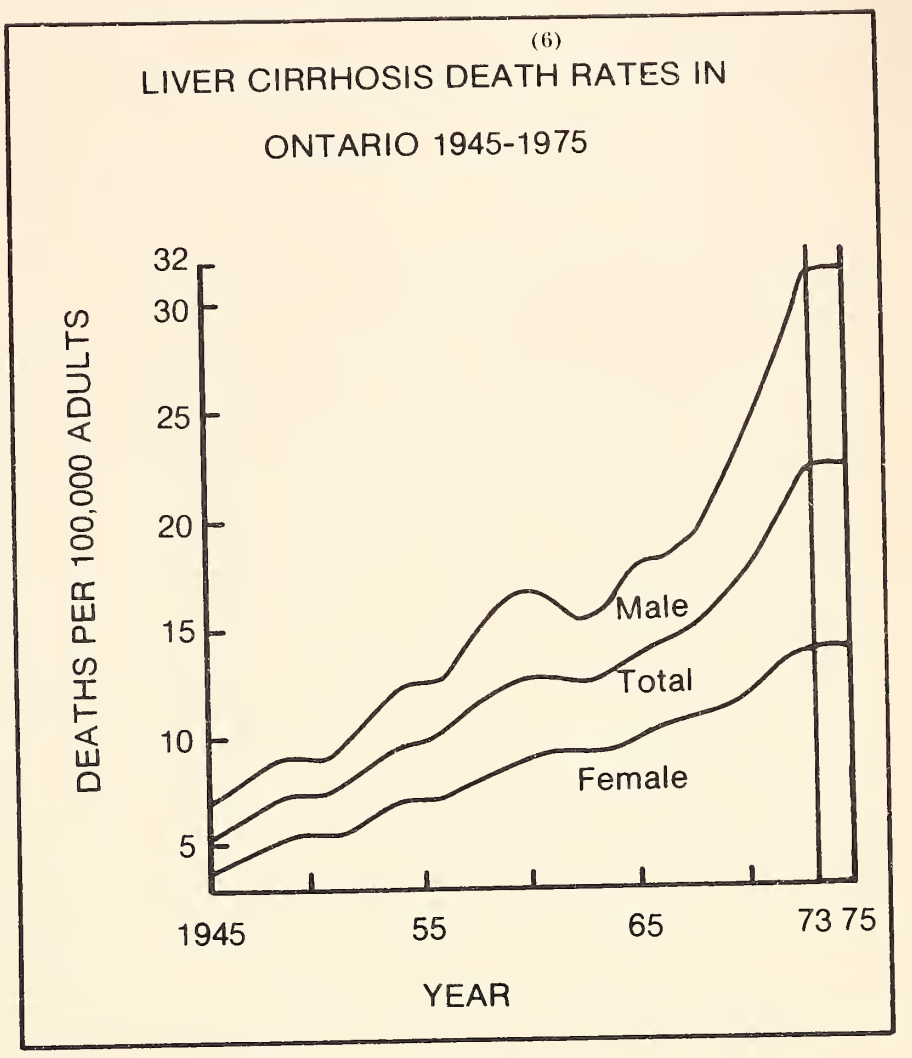
Further, in presenting its statistics on deaths due to liver cirrhosis, the impression is created that the death rate, which has been increasing up to 1973, will continue to do so. In fact, deaths from liver cirrhosis have levelled off since 1973, as shown in the revised graph (below). It is not known what later data on liver cirrhosis deaths may have been available at the time the paper was issued. However, total population rates of death from liver cirrhosis for 1973 to 1976 now available in published form are: 1973, 23.1 per 100,000 persons 25 years and over; 1974, 22.9; 1975, 22.0; 1976, 23.1.

We cannot fault the Foundation for not including data which may not have been available when the paper was prepared. However, we can point out that impressions based on outdated data can be misleading.

ADDICTION RESEARCH FOUNDATION PRESENTATION



ADDICTION RESEARCH FOUNDATION PRESENTATION PLUS TWO ADDITIONAL YEARS' DATA



Also, in Table 1 of the Strategy Paper the rate of change in the cirrhosis death rate between 1950 and 1973 is given as 8.80%, when in fact the correct figure is 4.79%.

We are not suggesting that there is any reason for being complacent about the deaths in Ontario due to liver cirrhosis. Even the death of one person from this cause is a tragedy. But, like the incomplete presentation of the sales trend of alcoholic beverages, this presentation on liver cirrhosis death rates would indicate that "scare" tactics are intended rather than objective analysis and conclusions which any reader would and should expect from a scientific body such as the ARF.

According to a report in the Addiction Research Foundation Journal (see Appendix IV), Dr Wolfgang Schmidt, the Associate Director of Research, conceded that in some of their work, *he and his co-workers could be justly accused of some overstatement and over simplification.* He is quoted as saying: *To a degree this was due to a deliberate strategy to secure a hearing for a point of view which ran counter to the prevailing sentiment. In retrospect, we now doubt the effectiveness of such a strategy and are inclined to take a more conservative approach.*

On the basis of this current ARF publication, we wonder if the ARF has abandoned its *deliberate strategy* of *overstatement* and *oversimplification* for *a more conservative approach.*

RELATIVE PRICE INFORMATION UNREPRESENTATIVE FOR BEER

Another major basis for the ARF policy recommendations rests in its analysis and conclusions of the effect of consumer prices of alcoholic beverages on levels of consumption.

Graph 4 (below) purports to show the prices of each type of alcoholic beverage in Ontario relative to the consumer price index in 1968 dollars (ie 1968 = 100). However, the labelling of the graph is misleading as the Ontario prices have been compared with the consumer price index for Canada, not for Ontario. Why the consumer price index for Canada was used instead of, say, the price index for Toronto, which is readily available, and why the year 1968 was selected as the base year is not stated.

In addition, the data presented in Graph 4 does not truly represent the consumer prices of alcoholic beverages relative to a consumer price index, since for beer at least the *consumer price* excludes:

(1) Ontario sales tax on packaged beer which rose from 5% to 10% in 1969;

(2) Ontario sales tax on draught beer which was imposed for the first time in April, 1972, at a rate of 10%; and

(3) Licensee mark-ups, which are currently about 168% of licensee price and have been increasing since 1968.

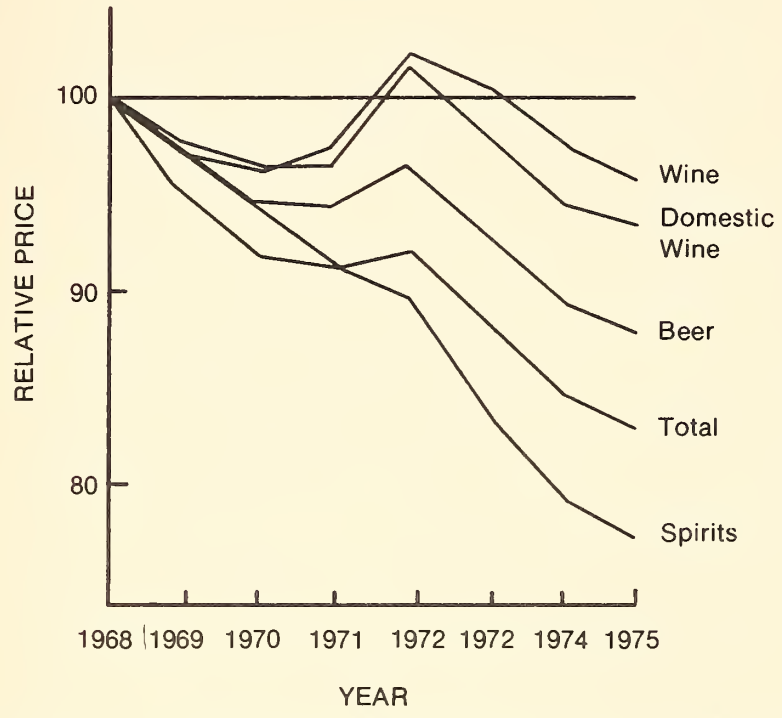
The true consumer price for beer (including sales tax and licensee mark-ups) compared to the consumer price index for Canada, or more realistically for Toronto, is shown in an amended Graph 4 (below).

While the brewers of Ontario do not have similar data for wines and spirits readily available, it is obvious from the graph that the true consumer price index for beer at all times since 1968 (with one exception) exceeded the consumer price index on either an "all Canada" or "Toronto" basis. As beer represents roughly one-half of the alcoholic beverages consumed in Ontario, the substantial error pertaining to beer will significantly change the *Total* figure.

ADDICTION RESEARCH FOUNDATION PRESENTATION

Graph 4

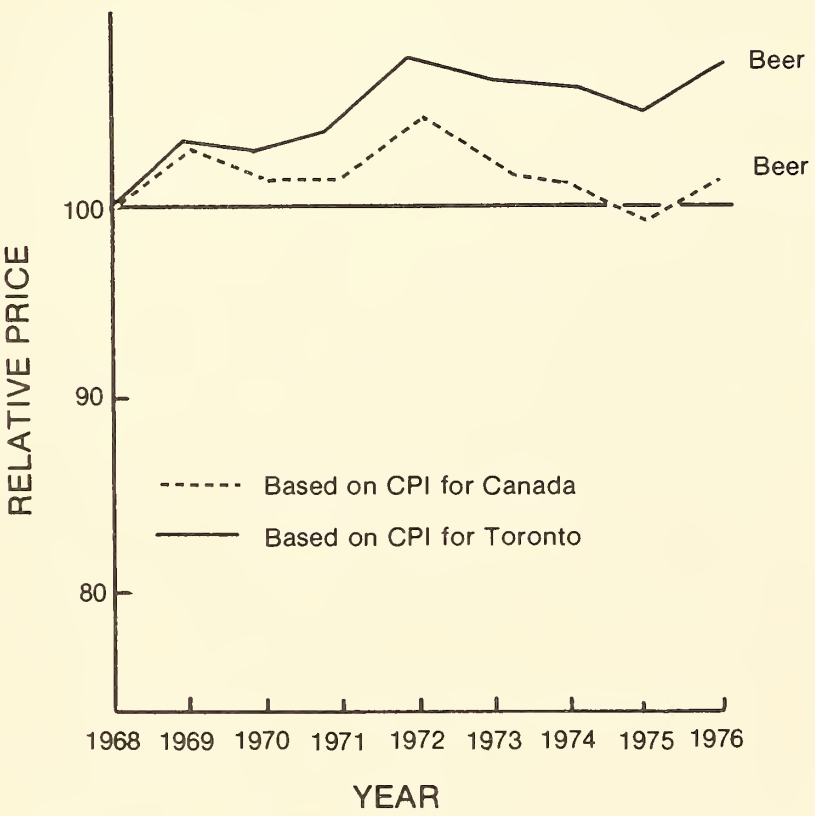
PRICES OF ALCOHOL BEVERAGES RELATIVE TO THE CONSUMER PRICE INDEX LEVEL, ONTARIC 1968-1975 (1968 = 100)



CORRECT PRESENTATION

Graph 4

PRICE OF BEER RELATIVE TO TORONTO CONSUMER PRICE INDEX AND CANADIAN CONSUMER PRICE INDEX (1968 = 100)



Once again, the data presented in the ARF paper has not included all the relevant information, at least with respect to beer, and in fact overstates and misrepresents the actual situation with which policy-makers must deal. Such poor quality of work surely is unacceptable to those who must use it in arriving at very important policy decisions.

SIMPLISTIC, NOT SIMPLE, ASSESSMENT OF LEGAL CONTROL MEASURES

To those who must deal with the complex and often conflicting issues of legal and regulatory control in the field of alcoholic beverages, the ARF evaluations of such matters as the impact of age limits, licensing regulations, advertising and taxation must appear simplistic and in places, contradictory, not merely simple.

For example, some of the conclusions and resulting recommendations contained in this ARF paper are:

Conclusions	Recommendations
Age Limits	
It does not follow from these findings that raising the drinking age would entirely undo the effects of lowering it. At present there is no direct evidence bearing one way or the other on this point.	*The legal drinking age should be increased.*
Licensing Regulations	
So far, it has not been possible to demonstrate specific adverse effects attributable to any one of these changes taken separately.	*There should be no further liberalization of alcohol control measures and a health-oriented policy with respect to such measures should be adopted.*
Advertising	
The impact of alcoholic beverage advertising on overall consumption is as yet poorly understood and, indeed, the problems of research on this topic are formidable if not insurmountable.	*Life-style advertising* (undefined) *of alcoholic beverages should be discouraged.*

In making the above observations, the brewers of Ontario are not implying that we "have all the answers" to legal control measures, or that, in fact, simple categorical answers are available. However, we do believe that if a research agency such as the ARF feels obliged to make policy recommendations to the Ontario government, such recommendations should be supported by thorough and accurate analyses, and not presented in simplistic and unsubstantiated terms.

ONTARIO POLICY-MAKERS DESERVE SOMETHING BETTER

In view of the recent changes in Ontario's policies and regulations regarding alcoholic beverages, it is not our intention to "cry over spilled milk" regarding the ARF strategy paper. The brewers of Ontario realize that the paper cannot be withdrawn, although such action appears warranted. Over 10,000 copies have now been distributed and presumably it will be judged by the professional and scientific community on its own merit.

However, we believe that it is important to examine how a publication of such questionable merit could emanate from a research agency substantially funded by the people of Ontario.

Research into a legislative and regulatory area as complex and sensitive as alcoholic beverages requires the utmost in objective professional study.

The brewers of Ontario do not believe that such standards have been met in the paper "A Strategy for the Prevention of Alcohol Problems".

Also, there is the question of why the ARF, a research agency which is responsible to the Ontario government, should have given such wide distribution to a paper setting out *recommended preventive strategy* after the government had established its policy.

The policy-makers, and the public, of Ontario deserve something better.

FOOTNOTES

(1) Although the Strategy Paper does not source the model from which the graph was derived, upon request, the ARF provided the Ontario brewers with a description of the model. It was prepared by Hung-Hay Lau, February 1977, and entitled, *Forecast of Ontario Consumption of Alcoholic Beverages 1975-1985.*

(2) *Canada's Economy — Medium-Term Projections and Targets*, Department of Finance, Canada, February 1978, page 61.

(3) It is interesting that the prediction of 1985 sales of 3.4 gallons as shown in the graph meant only a 29% increase over predicted 1975 sales.

(4) Note that there was virtually no change in sales from 1974 to 1976; sales in 1974 were 2.55 gallons; in 1975, 2.55 gallons; and in 1976, 2.54 gallons. Also, data available at the end of 1977 indicated little, if any, increase in 1977 as well.

(5) See, for example, Terris, M., "Epidemiology of Cirrhosis of the Liver: National Mortality Data"; *American Journal of Public Health*, 1967, 57, 2076-2088; *Alcohol and Health*, First Special Report to the U.S. Congress from Secretary of Health, Education and Welfare, 1971; Galambos, J. T., "Alcohol and Liver Disease", *American J. Digest, Dis.*, 1969, 14, 477-490; Jellinek, E. M., "Estimating the Prevalence of Alcoholism: Modified Values in the Jellinek Formula and an Alternative Approach", *Quarterly Journal of Studies on Alcohol*, 1959, 20, 261-269; Popham, R. E., "Indirect Methods of Alcoholism Prevalence Estimations: A Critical Evaluation", in Popham, R. E. (Ed.) *Alcohol and Alcoholism*, Toronto, University of Toronto Press, 1970; Ugarte, G., et al, "Clinical and Metabolic Disorders in Alcoholic Hepatic Damage", in Popham, R. E. (Ed). *Alcohol and Alcoholism*, Toronto: University of Toronto Press, 1970, 229-239; Wadman, B., et al, "Liver Cirrhosis in Three Scandinavian Communities", *Acta Med Scand*, 1971, 189, 221-230; and Brenner, M. H., "Trends in Alcohol Consumption and Associated Illnesses", *American Journal of Public Health*, Vol. 65, No. 12, December, 1975, 1279-1292.

(6) *Deaths per 100,000 Adults* are deaths per 100,000 adults 25 years and over. Liver cirrhosis death rates shown are two-year moving averages. Source of original data: *Causes of Death*, Statistics Canada Catalogue No. 84-203 and population as published by Statistics Canada.

APPENDICES

I A Strategy for the Prevention of Alcohol Problems: Background Information and Recommendations for the Parliamentary Debate on Control Measures, Addiction Research Foundation, Feb 17, 1978. (Reprinted in **The Journal**, June 1978).

II See below

III Article: "Booze: Still Canada's Biggest Drug Problem" (*The Globe and Mail*, Aug 22, 1978).

IV Article: "Consumption Curve Controversy Cools Down" (**The Journal**, July 1977).

Appendix II

Dates when more up-to-date data on factors used in model were available

Sales of Alcoholic Beverages

Latest actual used in model	— 1974
Latest actual available for the Addiction Research Foundation Strategy Paper:	
Beer, spirits and wine	— 1976 from 51st Report of the Liquor Control Board of Ontario April 1, 1976 to Mareh 31, 1977, dated Sept 29, 1977 and tabled in the House, Dec 1, 1977
Beer	— 11 months of 1977 from Brewers Association of Canada Sales Bulletins which the Addiction Research Foundation receives monthly.

Personal Disposable Income

Latest actual used in model	— 1974
Latest actual available for the Addiction Research Foundation Strategy Paper:	
Revised figures	— 1972 to 1975 from Statisties Canada, Oct 1977
1976	— available from Statistics Canada, Oct 1977
1977	— estimates available from several sources, eg Conference Board of Canada

Toronto and Ottawa Price Indexes

Latest actual used in model	— 1975
Latest actual available for the Addiction Research Foundation Strategy Paper:	— 1976 from Statistics Canada, Feb 1977
	— 1977 at least for three-quarters of year from Statistics Canada, Nov 1977.

Prices of Alcoholic Beverages

Latest actual used in model	— 1974
Latest actual available for Addiction Research Foundation Strategy Paper	— 1976 from 51st Report of the Liquor Control Board of Ontario April 1, 1976 to March 31, 1977, dated Sept 29, 1977 and tabled in the House, Dec 1, 1977
	— 1977 from retail prices available to public at all times.

ARF

ARF Response to the critique by the Brewers of Ontario entitled

"Ontario Deserves Something Better from the Addiction Research Foundation"

(November 1978)

The style of the critique by the Ontario Brewers* of our *Strategy for the Prevention of Alcohol Problems*† indicates that the main purpose is to discredit the work of the Foundation, at least that which relates to the issue of primary prevention. However, the Brewers Critique also contains a close scrutiny of some of our primary data and conclusions, and this we welcome. No one is immune to error and, therefore, any critique which stimulates a careful re-examination of one's work is of value. It is in this spirit that we have prepared the present response to each of the substantive points made in the Brewers' Critique.

Failure to use most recent alcohol sales data

In the chart showing our forecast of alcohol sales in Ontario, actual sales are plotted only to the year 1974. The Brewers' Critique argues that more recent data were available to us and that had we included these, our forecast would have been altered. The points relevant to the question of data available to us are as follows:

(1) For purposes of forecasting, alcohol sales have to be expressed on a *calendar* rather than a fiscal year basis because the various economic indicators employed are reported for calendar years. Since sales data are reported for the fiscal year, to estimate sales during the calendar year 1975, for example, requires that the data for the year ending March 31, 1976 be available.

(2) We have found that there are sometimes discrepancies between federal and provincial reports, and revisions of the figures in later years. Since our research involves both time trend studies and inter-provincial comparisons, we have found it to be best to use consistently a single standard source — in this case the reports on Control and Sale of Alcoholic Beverages prepared by Statistics Canada.

(3) The forecast was done for us by our consultant on economics, Dr H.-H. Lau, and completed in February 1977. At the time, the latest report on Control and Sale of Alcoholic Beverages was for the year ending March 31, 1975. The report for fiscal year 1975-76 was not published until October 1977. In any event, Dr Lau comments on this and related matters as follows:

"It should be pointed out that it is not necessary to include all available data points in the estimation of the model for use in forecasting. As long as the structure of the equation is judged to be reasonable on economic grounds, the model need not be re-estimated each time an additional observation becomes available. For instance, the Red Book version of the Bank of Canada RDX2 econometric model of the Canadian economy which was released in 1977 includes data points up to 1972 only. Today, it is still widely used by government agencies including the Department of Finance and the Bank of Canada in making policy simulations.

"In fact, one can point out a potential danger of incorporating all available data points in estimation because data for the most current observation may be revised subsequently. A clear example concerns the value of beer sales for the province of Ontario recorded for the financial year ending on March 1976. The figure was reported in October 1977 to be $560,655 thousand. In September 1978, this sales value was revised downwards to be a mere $463,725 thousand even though there were no revisions in the corresponding volume figure. This revision has resulted in a substantial change in the calculated average price of beer for both calendar years 1975 and 1976. If we had included the preliminary figure in our estimation, we would have to revise the econometric model now to incorporate the recent data correction. In the case of the equation for beer, it is clearly better not to include preliminary data for financial year 1976.

"In other words, we are justified in using the model which was estimated based on final data not subject to revision, even though data for 1975 and 1976 have since become available. Given the good performance of the model in the historical period, we should have confidence in the medium-term predictions even though the short-term predictions may be off-track when compared with preliminary data which have just become available. Over the 1966 to 1967 period, alcohol consumption levelled off unexpectedly contrary to model prediction. In the following period from 1968 to 1971, consumption rebounded strongly. It is quite likely that following the levelling off of consumption in 1975 and 1976, there will be a rebound similar to the experience in the late 1960s."

The Use of Unrealistic Economic Values and Its Impact on the Forecast

The Brewers' Critique notes that the inflation rate and the rate of increase in the price of beer used in the forecast were unrealistic. We agree that this indeed proved to be the case. The relevant questions then are: (1) why were these values used, and (2) what is the impact on the forecast. Dr Lau comments as follows:

"In the forecast, the assumed rates of growth in the CPI and in the price of beer were based on the 1961 to 1974 trend rates of growth for the series concerned because public forecasts for these variables were not available. Clearly, such rates, viewed separately, appear to be unrealistically low in view of recent inflation experience. However, what is important in determining alcohol consumption is the *real price* (nominal price divided by the CPI) of alcoholic beverages and real income as well. If the historical trend rates have underestimated alcohol prices, they have also underestimated the CPI. These underestimations tend to offset each other. For example, if we raise both the CPI and the alcohol prices by the same proportion, we do not change the real price of alcoholic beverages. In effect, the volume of consumption remains unchanged from the levels predicted in the forecast.

"As a matter of fact, our predictions of the changes in the real prices of beer and spirits for calendar year 1975 were extremely good. (We prefer not to use 1976 data because they are subject to revisions.) For example, we predicted a 2.3% decline in the price of beer relative to the CPI compared with the actual decline of 2.0%. For spirits, the prediction was a decline in real price of 3.1% versus an actual decline of 2.8%."

Per capita sales rates overstate by 30%

The Brewers' Critique states that "Per capita sales are in fact sales per adult 15 years and over, and thus overstate consumption by more than 30%."

In the field of alcohol studies, it has become standard practice to express alcohol sales or apparent consumption rates in terms of the 'drinking age' population, ie, persons 15 years of age and older. The validity of this practice is well established by a large body of survey and other data respecting the distribution of alcohol use in general populations. As the epidemiologist would put it: the drinking age population is the best regularly available approximation to the population at risk.

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* Cited for convenience throughout as the Brewers' Critique.

† Cited for convenience throughout as the Strategy Document.

We acknowledge that the designation in the graph cited in the Brewers' Critique might have been more explicit on this point. Certainly when the forecast was originally reported in the scientific literature full details were provided. However, in the present instance, it was felt to be desirable in the interests of effective communication to simplify labels and keep footnotes and documentation to a minimum. The primary purpose of the graph, after all, was to indicate the trend, not the level of consumption.

Finally, while it is obvious that a per capita sales rate based on the population of drinking age (15 and older) will be greater than one based on the total population, this is not to say that the former overstates the average consumption of those who use alcoholic beverages. In fact, the rate based on drinking age *understates* average consumption since only about 80% of persons 15 and older use alcoholic beverages.

Error in expression of rate of increase in sales

Our statement in the Strategy Document that the predicted 1985 sales figure is 50% greater than in 1975 is incorrect, as noted in the Brewers' Critique. This was due to a regrettable error in transcribing data from Dr Lau's original report. The statement should have read: "34% greater than in 1974."

We also agree that our wording: "present rate of increase" may be misunderstood by many. The forecaster employs the term "present" with reference always to the latest data in his analysis. The meaning we intended was "the rate of increase over the historical period covered by the forecast".

Liver cirrhosis mortality as an indicator of the prevalence of alcohol problems

The Brewers' Critique claims that many investigators in the field of alcohol research do not accept the view expressed in the Strategy Document that: "There is no better indication of the trend in the prevalence of alcohol-related health problems than changes in the rate of death from cirrhosis of the liver."

First we must note that, with one exception, the works cited in support of the Brewers' contention are 7 or more years old. This is a highly active area of investigation and much has been learned in the past decade. Indeed, even by 1975 an international group of researchers meeting under the auspices of the World Health Organization concluded that: "The relationship between heavy consumption and excess mortality is manifested in the general population in a covariation of liver cirrhosis mortality and per capita alcohol consumption." (1) Secondly, at least four of the authors (Jellinek, Popham, Terris and Ugarte) are miscited in this context. For example, Jellinek and Popham were concerned with technical shortcomings of the Jellinek Estimation Formula and *not* with the validity of cirrhosis mortality as an indicator of alcohol-related health problems. In fact, the Popham paper cites evidence in support of the latter.

Finally, ARF researchers have probably done more work on this topic — biological, clinical and epidemiological — than any other group. Some of this work is quite recent and, while published, may not yet have reached the scientific community at large.

Current plateau in liver cirrhosis mortality

As in the case of sales data, the Brewers' Critique faults us for giving a misleading impression of trends through the use of outdated cirrhosis mortality data.

The latest vital statistical report available at the time was for the year 1974. Since we employ centred two-year moving averages (in order to remove the chance fluctuations in rates to which such causes of death are liable), the estimate for 1973 was the most recent which could be calculated.

The Brewers' Critique attributes considerable importance to the apparent plateau in cirrhosis mortality 1974-1976. We can only point out that such plateaus and even reductions have occurred before (as shown in our graph), and proved to be temporary aberrations in the long run.

Parenthetically, in the Strategy Document we cited the now well-established principle that "the overall level of consumption is directly related to the magnitude of alcohol problems". Given that the cirrhosis death rate is an indicator of the prevalence of such problems (as noted in the previous section), a plateau in the rate would be expected to accompany the plateau in alcohol sales.

Calculation of percent increase in cirrhosis rates 1950-73

The Brewers' Critique argues that the correct rate of change in cirrhosis death rates over the period 1950 to 1973 is 4.79% rather than the 8.80% reported by us in the Strategy Document. Our figure is the average increase in the death rate *expressed as a percentage of the base year (1950)*. The Brewers' figure represents, in effect, the average increase *expressed as a percentage of each preceding year*. Both methods of calculation are legitimate. The one is often used by epidemiologists, the other by economists and demographers. In the present instance, it matters little, since a graph of the trend and the actual death rates for 1950 and 1973 were provided in the Strategy Document. These data convey the essential point, namely, that the rate almost tripled over the period.

Citation of statement respecting oversimplification

The Brewers' Critique quotes Schmidt, one of the authors of the Strategy Document, as saying that "he and his co-workers could be justly accused of some overstatement and oversimplification". This statement is quoted out of context. Schmidt was addressing a group of scientific colleagues and meant that we sometimes did not put in all the traditional qualifiers. He did not mean that we lacked confidence in our main conclusions.

Trends in the price of alcoholic beverages

The Brewers' Critique questions three aspects of our analysis of recent trends in the real prices of different classes of alcoholic beverage. The first question concerns our use of the Canadian Consumer Price Index (CPI) rather than that for Toronto. We felt that neither index was ideal, but that the Canadian CPI, being based on both large and small cities, would be a better approximation than one based on a single very large urban centre. For example, when the CPI's for Toronto and Ottawa are compared it is found that the percent increase over the period 1968-77 is greater for the smaller city (74.4% versus 70.6%). In the absence of data for a sizeable sample of Ontario cities, another possibility is to employ a weighted mean of the Toronto and Ottawa indexes. We have calculated such means for the period and employed them in our re-analysis of price trends discussed below.

The second question raised in the Critique concerns our use of the year 1968 as the base year. We picked this year because in our previous (1973) submission to Government, we had provided data up to 1969. The two year overlap was necessary to to provide a sufficient number of years to determine the trend.

Finally, the Brewers' Critique states that our conclusion that the real price of beer has declined is invalid because we failed to take into account increases in the Ontario sales tax and in licensee mark-ups. Our source of price data was the Statistics Canada reports — Control and Sales of Alcoholic Beverages. The data in these reports do not include the Ontario sales tax and we overlooked it as a result. Certainly the increase in 1969 has to be taken into account. However, this does not affect the direction of the trend but shifts the price level upwards by 5% from 1969 on.

We disagree with the contention of the Brewers' Critique that increases in the cost of alcoholic beverages to customers of licensed drinking places should have been included. In the first place, only about 25% of all sales of Canadian beer is to licensees, (2) and the proportion is less for the other beverages. In fiscal year 1978, about 13% of the dollar value of sales of wine, spirits and imported beer represented sales for on-premise consumption. (3) Secondly, the cost of alcoholic beverages will, of course, be greater in licensed establishments, but this cost covers also services, entertainment, decor, location, etc. For the purposes at hand, we are interested in the retail cost of the alcoholic beverage only, since this is the important factor from the standpoint of control policy formulation. To be quite certain as to the nature of the relevant trend, it is best to consider the retail price to the consumer of packaged beer as most commonly purchased, and of the least expensive domestic whisky and sherry. The results are shown in Table 1. With one exception (sherry), the increases in beverage prices have been less than those in the CPI's.

In Table 2 a comparison of the Toronto CPI's for all goods, for soft drinks and for alcoholic beverages is shown. This comparison is of particular interest since the two kinds of beverage may serve as substitutes for one another depending, among other factors, on their relative cost. Over the period for which the data were available (April 1973 — September 1978) the index for all goods increased by 50.3%, that for soft drinks by 63.3%, while that for alcoholic beverages increased by 35.2%.

Table 1

Consumer Price Indexes (1968 = 100), and the Price to the Consumer (excluding bottle deposit but including Ontario Sales Tax) of Canadian Beer and the Least Expensive Rye and Sherry in Ontario 1968-1977*

Year	Consumer Price Index for:			Dollar cost of:			
	Canada	Toronto	Toronto-Ottawa	12 small beer	24 small beer	25 oz. least expensive rye	26 oz. least expensive sherry
1968	100.0	100.0	100.0	2.30	4.30	5.00	1.00
1969	104.5	104.0	104.0	2.38	4.45	5.25	1.05
1970	108.0	106.7	106.9	2.41	4.50	5.25	1.05
1971	111.1	108.6	108.9	2.47	4.60	5.25	1.05
1972	116.4	112.9	113.3	2.64	4.90	5.50	1.20
1973	125.1	120.7	121.2	2.70	5.00	5.50	1.20
1974	138.9	133.4	134.0	2.92	5.35	5.90	1.40
1975	153.9	147.6	148.0	3.20	5.79	6.40	1.60
1976	165.4	158.4	158.9	3.42	6.24	6.70	1.60
1977	178.6	170.6	171.3	3.66	6.63	7.00	1.80
Percent Change	+ 78.6	+ 70.6	+ 71.3	+ 59.1	+ 54.2	+ 40.0	+ 80.0

*CPI's were obtained from: "Price and Price Indexes", Statistics Canada. The Toronto-Ottawa CPI was calculated by taking a weighted mean of the indexes for Toronto and Ottawa. The weights were 0.81337 and 0.18663 respectively. The dollar cost of beer is the weighted mean cost over the calendar year, taking into account the month when a change in price occurred. The data on beer prices and price changes were provided by Brewers' Warehousing Co Ltd, Nov 24, 1978. Rye and Sherry prices for 1968-1972 inclusive, and for 1975 were obtained from "Ontario Liquor Store Price List"; those for other years were obtained by phone on Nov 27, 1978 from Mr Jackman, Comptroller, LCBO.

Table 2

A Comparison of the Toronto Consumer Price Indexes for all Goods, Soft Drinks and Alcoholic Beverages, April 1973 - September 1978*

Year	CPI All Goods	CPI Soft Drinks	CPI Alc. Beverages
1973	91.4	80.9	95.2
1974	100.0	100.0	100.0
1975	110.7	121.5	110.0
1976	118.7	121.4	116.8
1977	127.9	120.9	123.2
1978	137.4	132.1	128.7
Percent Change	+ 50.3	+ 63.3	+ 35.2

*CPI's for all goods were obtained from: "Price and Price indexes", Statistics Canada; for beverages from: Mr H. Harnarine, Prices Division, Statistics Canada, (Information received December 7, 1978). The indexes for 1973 refer to the period April to December, and those for 1978, to the period January to September inclusive.

Apparent inconsistency of Our Recommendations

The Brewers' Critique contends that our evaluation of legal and regulatory controls is simplistic and in places contradictory, and that our recommendations are "presented in simplistic and unsubstantiated terms". Specifically, the Critique cites three recommendations which are held to be contradicted by statements which we make in the body of our Strategy Document:

(1) *Recommendation to increase the legal drinking age.* We did, indeed, state that there was not yet evidence to indicate that raising the limit would undo the effects of lowering it; and we suggested as well a possible adverse effect of raising the limit. However, we also noted possible benefits, namely: the probability of some reduction in consumption and attendant problems, the facilitation of the control of alcohol-related disciplinary problems in schools, and the educational value of such an expression of government concern for the health problems of the young. Our recommendation, therefore, was based on our best judgment of the *balance* of costs and benefits.

(2) *Recommendation to discourage life-style advertising of alcoholic beverages.* This recommendation was also based on our best judgment as to probable impact rather than on direct evidence. Thus, we said "it is reasonable to postulate that advertising which portrays alcohol use as a natural and desirable part of everyday life increases acceptance of drinking and, hence, potentially, the level of consumption in the population." Indexes of acceptance have, in fact, been shown to be positively related to level of alcohol consumption. However, the crucial point is that we judge it to be inconceivable that an increase in social acceptance would be conducive to a reduction in use. We found in a survey of public attitudes in Ontario that there appears to be a majority sentiment in favor of the use of alcohol control measures to the end of health protection. The question is whether one wishes to capitalize on this sentiment to introduce health objectives into the control system, or seek through advertising and other means to alter sentiment to support still greater use of alcohol than at present. Clearly our mandate is to encourage the former.

(3) *Recommendation for a moratorium on the liberalization of alcohol control measures.* We did point out, as the Critique notes, that so far it has not been possible to demonstrate specific adverse effects attributable to any one of various small changes in licensing regulations taken separately. But we also noted that over the post World War II period the cumulative effect of the many small changes represented a major alteration in availability. It *has* been demonstrated that *major* alterations do have a significant impact on consumption and the prevalence of alcohol-related health problems. (4) Again our recommendation was an expression of our best judgment of probabilities given the evidence available. As the point is anything but simplistic, it is perhaps important to consider it here in more detail than seemed desirable in a document intended primarily for legislators who do not have time to read lengthy submissions. To this end we refer to a recent response to an enquiry from the President of an Ontario university. The President sought the Foundation's opinion as to the pros and cons of opening a pub on his campus. In our reply the following points were made:

(1) There is evidence that neither per capita alcohol consumption nor the prevalence of alcohol-related problems such as drunkenness and alcoholism are appreciably (or, at any rate, measurably) affected by *minor* changes in the number of sales outlets per unit of population. On the other hand, a *substantial* change in availability in either direction does have an effect: a drastic reduction is accompanied by a decline in problems of alcohol; a large increase, by a rapid rise.

(2) Clearly the university proposal is in the category of a minor change. It involves the addition of a single outlet in an area already well supplied. Under these circumstances, it is unlikely that any significant increase in adverse effects on the campus population would occur. The main impact would probably be to shift some drinking (and some related problems) from existing outlets to the new one.

(3) Given this conclusion, current relatively liberal attitudes towards alcohol use, and the benefits which might be cited in favor of a pub (eg revenue for the university, pleasure and convenience for its patrons), it is very likely that the pros will be seen to outweigh the cons.

(4) However, there is another aspect to the matter. Until very recently, the changes in the alcohol control system in Ontario over the past 30 years have all been in the direction of liberalization. The trend has clearly been towards the introduction of alcoholic beverages in all aspects of everyday life; that is, towards the alcoholic saturation characteristic of some parts of the United States and Europe which lead the world in the prevalence of alcohol-related health problems.

(5) So far, it has not been possible to demonstrate specific adverse effects attributable to any one of these changes taken separately, save the lowering of the legal drinking age (which was followed by an increase in alcohol-related traffic accidents and in clinical admissions for alcoholism). Nevertheless, the conclusion seems inescapable that the cumulative impact has been very great, and highly undesirable from a public health perspective. For example, since 1950, mortality from liver cirrhosis — known to be a sensitive index of the prevalence of alcohol problems generally — has shown the largest rate of increase of any cause among adults in Ontario.

(6) From this standpoint, it may be argued that the university is contemplating another of the numerous minor changes typical of recent alcohol control history in Ontario, and that the change would contribute to the cumulative effect noted. Also, the change would communicate a message respecting the attitude of the governing body of the university towards the use of alcohol in its community. The message would serve to reinforce the liberalizing trend in our society with the consequences stated for public health. Thus, the proposed change ought to be seen not in terms of its specific immediate effects, but in a much broader context: the context of a health-oriented policy respecting alcohol consumption.

(7) The adoption of such a policy would probably encounter many difficulties, not least of which would be the communication of its justification to faculty and students. In the current climate, were this not done well, actions consistent with the policy — involving, eg resistance to further relaxation of controls — would likely be written off as a reflection of out-moded puritanism on the part of the members of the university government. In any case it would seem to be well worth the attempt. Recent survey evidence suggests that, contrary to the view which seems to dominate the mass media, there is still a majority in Ontario who favor controls where health protection can be seen as the underlying rationale.

Conclusion

Having re-examined, in the light of the Brewers' Critique, the evidence and arguments underlying our Strategy Document, we do not see any reason to alter either our conclusions or recommendations. Inevitably, the translation of conclusions into recommendations involves going beyond the scientific evidence and introduces an element of judgment. The guiding principle for us was that, where there is uncertainty as to the probable costs and benefits of alternative courses of action, the course to be recommended should favor public health.

FOOTNOTES

(1) Bruun et al. Alcohol Control Policies in Public Health Perspective. The Finnish Foundation for Alcohol Studies, Helsinki, Vol 25, 1975, p. 90.

(2) This figure was provided by Mrs Sharon Baker of Brewers' Warehousing by phone on Nov 28, 1978.

(3) These figures were provided by Mr John Noble, chief accountant, Liquor Control Board of Ontario on Dec 4, 1978.

(4) Bruun et al. Alcohol Control Policies in Public Health Perspective. The Finnish Foundation for Alcohol Studies, Helsinki, Vol 25, 1975.

NEXT MONTH:

Further comments from the Brewers and the Addiction Research Foundation.

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Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.

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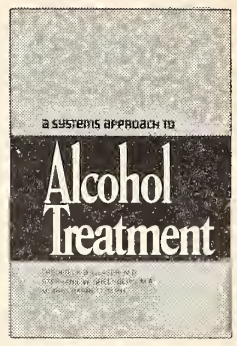

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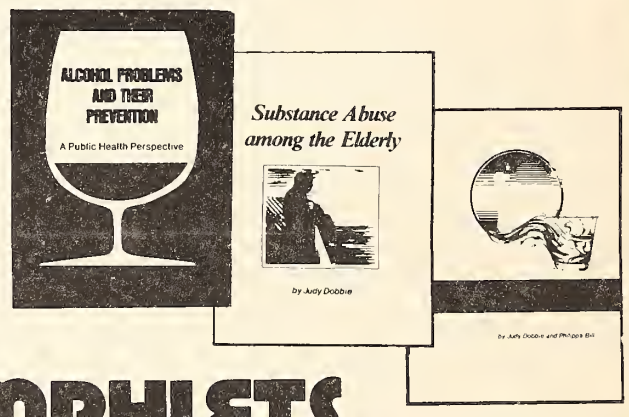

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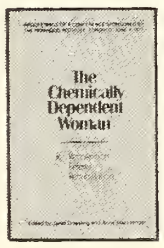

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France waking up to seriousness of alcoholism

PARIS — The French mentality regarding alcoholism seems to be changing, and the French now recognize the dangers of alcoholism and even support "repressive" anti-alcoholism measures, say leaders of the Comité National de Défense contre l'Alcoholism.

"1978 was a relatively good year," said Jacques Godard, of the Comite. "There were two laws passed. One — calling for the treatment of alcoholism in all general hospitals — went almost unnoticed by the press and general public although it was very important to us.

Official position

"For many years, the official position in France has been that alcoholism is treated in mental hospitals, which is only a part of the problem. This sort of attitude means that when someone drinks too much and breaks a rib, the rib will be taken care of in the hospital but not the drinking.

"For years we have been fighting for the treatment of alcoholism in general hospitals — so that, for example, the doctor treating the broken rib will call in someone to try to deal with the drinking. Now we have a law that recognizes this way of thinking."

The second law, authorizing preventive breath tests and providing stiffer sanctions for drunk drivers, received extensive media coverage. "Never have people talked about alcoholism so much," Dr Godard said.

A veteran in the French anti-alcoholism fight, Dr Godard still seems a bit surprised the second law was passed at all in a country of rampant individualism and political polarization. "We have been astounded by the good will with which people have accepted the controls," he said.

The traditional French pastime of a drink with conversation is coming under scrutiny of a government and public increasingly worried about the nation-wide consequences of alcoholism.

The publicity surrounding the law's passage was based on the slogal *il faut choisir*, "you must choose" and Dr Godard explained that it was another way of saying "if you drink, don't drive; if you drive, don't drink".

Publicity

Besides the roadside screening and stiffer sanctions, the new law also lays the legal groundwork for conviction on the basis of breathalyzer tests alone. In the past, explained Dr Godard, the Draeger tests in use had to be verified by blood tests.

"By the time the police could locate a doctor to take blood, a significant amount of time had usually elapsed and the blood alcohol had had time to fall," he explained.

The law has apparently been responsible for a decrease in traffic deaths (see box) although Dr Godard notes that this may be due more to the publicity than to the law itself.

"The experience of other countries has shown that once the novelty wears off, traffic accidents tend to climb again, and the law should be changed from time to time for this reason. Everybody seems to have forgotten that France already had a law authorizing breath tests (passed in 1970 and allowing breath tests only if a traffic violation had been committed)."

There has also undoubtedly been a drop in alcohol consumption, he said, although it is impossible to say how much or whether it will last.

"When the law first went into effect, certain cafe owners and alcohol sellers announced that the sales of aperitifs and spirits had fallen by as much as 80%. That was clearly an overstatement, and it is possible that a real drop was followed by a return to normal in a month or two."

But Dr Godard noted that while other countries have not registered a drop in overall consumption following roadside screening, France is the first country with a "Latin" drinking pattern (most alcohol consumed is wine, with the meal) to have passed such a law.

Paying off

Since the law is expected to change the pattern of drinking, it is possible the effect here on overall consumption will be different than elsewhere. He points out that France is the only country in the world where alcohol consumption is not rising, and that for the past 10 years there has been a slight decrease.

"We don't know why," he said. "It's probably not saturation, since there are still quite a few people in France who don't drink much. We would like to believe that the educational campaigns of groups such as ours are finally paying off."

Public backs road screens

PARIS — Road deaths dropped more than 7% in France in 1978 as compared to 1977; and most of the drop occurred in the last six months of the year, when the law allowing roadside screening was in effect, according to statistics released by La Securité Routière, an interministerial committee.

The committee reported that while in the first six months of the year there were 139 fewer deaths than in the previous years, in the last six months there were 828 fewer deaths.

The drop in deaths occurred despite an increase of 5% in traffic, according to La Securité Routière.

Serious injuries in road accidents decreased by more than 5%, and slight injuries by almost 5%.

Public opinion, which has largely been positive, has become even more so, said a spokesman for the group. In August, shortly after the law's passage, 66% of the population approved the law and 26% disapproved. In December, 76% approved and 19% disapproved.

When asked if the number of drunken drivers was increasing or decreasing, in July 29% of those polled said it was increasing and 17% that it was decreasing. By December, only 9% thought the number of drunken drivers was increasing, compared to 49% who thought it was decreasing.

Positions Available

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Applicants must possess demonstrated theoretical and practical knowledge of and be experienced in alcohol and drug prevention, treatment and rehabilitation programs, including experience in working with diverse cultural, community and counselling groups. Applicants must further possess demonstrated capability in long range planning, analysing existing programs and possess liaison and communication skills in dealing with various groups and agencies.

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Grocers continue war on gov't liquor stores

By John Carroll

MONCTON — Despite a recent rejection of the idea by the New Brunswick government and the disapproval of Everett Chalmers, chairman of the provincial Alcohol and Drug Dependency Commission, efforts are still being made to persuade the government to end the Liquor Corporation's monopoly on sales of alcoholic products by permitting sales in small grocery stores.

The subject arose in December, 1978, when a chain of Fredericton area convenience stores surveyed customers as to whether beer and wine should be sold in such outlets.

Alex Scholten, of Scholten's 7 to 11 stores, said 15,000 ballots were used and the results had been sent to the finance and tourism departments.

Finance Minister Fernand Dube then said the survey showed approximately 80% of the respondents favored beer and wines in small stores, with 70% favoring sale seven days a week. Mr Dube said he personally supported such a change.

Fernand Dube, New Brunswick's Finance Minister, changed his mind.

The immediate response from Dr Chalmers was that alcohol should not be made more available. He said sale of beer and wine at convenience stores would be a novelty and would result in more consumption. Teenagers would have greater accessibility to alcohol, and "skid road types" would hang around such stores.

Just before Christmas, the New Brunswick Liquor Corporation (NBLC) turned thumbs down on the idea, provoking Mr Dube to reprimand NBLC Chairman Alfred Landry through the media: "Mr Landry is administering the laws that we give him." Mr Dube reiterated his support for small-store beer and wine sales, saying he felt this would enable them to compete with major retail outlets.

But in early February, the finance minister had a change of heart. He said he had ordered a committee in his department to study the matter and after evaluating their findings "I will not recommend to the government or the Legislature that beer and wine be sold in convenience stores."

A little over a month later, at a news conference here, Derek O'Neil, president of Green Gables Food Stores Limited, a Halifax-based chain of 58 convenience stores in Nova Scotia and New Brunswick, unveiled a survey carried out in the 10 New Brunswick outlets.

In a letter to the finance minister, Mr O'Neil said: "During a three-week period we carried out a very low key, random survey of our customers over 19 years of age .... the following statistics were obtained. 3,414 petitions were completed, 642 (18.8%) were against having beer and wine in convenience stores, 384 (11.3%) wanted beer only, 28 (.8%) wanted wine only, 2,360 (69.1%) however requested both beer and wine. 490 said they would not want to buy beer and wine on Sunday."

Mr O'Neil said New Brunswickers were paying "a colossal premium" of more than 10 cents a bottle of beer for home consumption, compared to Montrealers. He said this was difficult to understand in view of the fact breweries in Quebec have to supply 9,000 small retail outlets, yet in New Brunswick there are only 65 government liquor stores to be serviced.

He said the per-bottle cost to the consumer of beer sold in a case of 24 is 29 cents in Quebec, compared to 43.33 cents in New Brunswick. He suggested competition could bring prices down.

Mr O'Neil said he did not consider the finance minister's rejection of the concept killed the matter. "We're going to continue this.

"If we, as operators of convenience stores, could be shown that the rate of alcoholism would definitely increase in the province if we should be allowed to sell beer and wine, Green Gables would not want to sell these items."

Strike behind reduced NB liquor sales

FREDERICTON — The first year of non-growth in the sales of the government liquor monopoly in New Brunswick took place in fiscal 1977/78. But those who would be encouraged by this probably are doomed to be disappointed.

Reduced sales of the New Brunswick Liquor Corporation (NBLC) in the year ended March 31, 1978, do not necessarily reflect reduced consumption by the 677,000 residents of the province.

After years of steadily increasing sales of alcohol, the turndown shown in the recently-released report of the Liquor Corporation is attributable to a two-month long strike by NBLC clerks.

During the Aug 19-Oct 14, 1977, work stoppage, residents of New Brunswick flocked to liquor stores at convenient points in neighboring provinces. RCMP carried out many searches of motor vehicles and charges were laid where amounts exceeded permissible importation levels.

At the same time, although the liquor stores were closed, management personnel continued to operate warehouses, and the NBLC imported beers from other provinces and the United States, when local breweries were caught in the strike as their union workers took action in sympathy with the liquor clerks.

So the figures in the 1977/78 NBLC Annual Report tell only part of the story. They show that gross sales for the year ended March 31, 1978 were down to $95,979,010 from $99,657,797 the previous year. Net income on these sales decreased to $31,781,727 from $33,080,211.

New Brunswickers still prefer beer over all other beverage alcohol products, and at $47,506,174 in gross sales, beer represented 49.5% of the total. Spirits accounted for $40,396,452 or 42% of gross, while wines totalled $8,076,384 or 8%.

The NBLC operated 65 outlets or one for every 1,040 New Brunswickers. Its sales represented nearly $142 in alcoholic beverages for every man, woman, and child in the province.

Since 1976/77 sales were $99,657,797 or $147 per capita, it is reasonably safe to assume that the difference in apparent consumption may well have been made up by purchases made in neighboring provinces during the strike. It is equally safe to assume that had the strike not occurred, the progressive climb in sales and consumption in New Brunswick would not have been interrupted, albeit perhaps only statistically.

The strike hit hardest at distillers, for sales of spirits were off by $3.5 million on gross. Wines were down $157,000, but beer suffered only the most marginal of decreases, with gross sales down only $35,000.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

An Ounce Of Prevention

Subject Heading: Youth and alcohol.
Details: 14 minutes, 16 mm, color, sound.
Synopsis: Fat Albert and the Cosby kids are playing baseball when Lucius shows up to demonstrate some magic tricks. At times Lucius is friendly and willing to teach his friends these tricks, but at other times he is mean and impatient. Concerned about Lucius' changes of mood, Fat Albert follows Lucius and finds him drinking alcohol secretly. Lucius tells Fat Albert he drinks because his parents don't care about him. Not knowing how to help him, Fat Albert consults his own parents. Fat Albert's parents invite Lucius' parents to their house to tell him what is happening. Luckily, Lucius' parents have already found out and are getting help for him.
General Evaluation: Good (4.3). A contemporary, interesting, and technically well produced film with a clear message, this film could be an effective teaching aid. Its length was also judged suitable for most educational uses.
Recommended Use: Likely to benefit audiences of eight to 14 years of age.

Alcohol: What's In It For Me?

Subject Heading: Youth and alcohol.
Details: 13 minutes, 16 mm, color, sound.
Synopsis: A student decides to do a school project on alcohol. He talks to people and finds out why they drink. For example, one girl drinks because she feels uptight about an exam; another girl drinks because she doesn't like herself. The student displays charts which explain what alcohol is, and how it affects people.
General Evaluation: Poor (2.0). This film was boring, poorly acted, and had little impact. It received moderate ratings in all other categories.
Recommended Use: The film seemed to be intended for audiences of 12 to 18 years of age. However, the film was seen as having little benefit.

New Books

by RON HALL

The Drinking Women

. . . by Edith Lynn Hornik

Through a series of interviews in halfway houses, with women's groups, and with other individuals, the author has uncovered the social dynamics which create problem drinking among women. This book describes the life of an alcoholic woman and the role of the family in helping her. It discusses the feminist attitudes that may contribute to her drinking, and those that may help her recovery. The role of Alcoholics Anonymous and other sources of help are related. Stress and family living, pregnancy, the alcoholic woman in the unhealthy marriage, and life with an alcoholic are other topics which are considered.

(Follett Publishing Company, 1010 West Washington Blvd, Chicago, Illinois, 60607, 1977. 191p. $8.95)

Other Books

Drug Dependence: Current Problems And Issues — Glatt, M. M. (ed). University Park Press, Baltimore, 1977. Papers from an international group of scientists on the nature, medical complications, treatment, and prevention of drug abuse. 332p. $34.25.

Drug Abuse: Modern Trends, Issues And Perspectives — Schecter, A., Alksne, H., and Kaufman, E. (Jt eds). Marcell Dekker, New York, 1978. Proceedings of the 2nd National Drug Abuse Conference, New Orleans, Louisiana, 1975. Epidemiology, treatment, personnel: Clinical pharmacology, narcotic antagonists, LAAM: Drug dependent mothers and infants: Evaluation of drug abuse treatment; minority issues. Name index. 1, 229p. $51.75.

Guide To The Investigation And Reporting Of Drug-Abuse Deaths: Problems And Methods — Gottschalk, L.A (ed). National Institute on Drug Abuse, Rockville, 1977. Appendices include ICDA code categories. Index. 151p. $13.

Problems Of Drug Abuse In Britain — West, D. J. (ed). Institute of Criminology, Cambridge, 1978. Papers presented to the Copwood Round-Table Conference, Dec, 1977. "British system": accidental self-poisoning: cannabis. 217p. £8.50.

Developments In Opiate Research — Herz, A. Marcel Dekker, New York, 1978. Receptors: Endorphins: Sites of action: Actions of opioids on single neurons: Isolated organs used in opiate research: Brain catecholamines: Cyclic nucleotides. Index (Modern Pharmacology — Toxicology Vol 14). 432p. $46.

Alcoholism And Its Treatment In Industry — Schramm, C. J. (ed). Johns Hopkins University Press, Baltimore, 1977. Costs: Unionism: Case Studies: Research. Index. 191p. $14.87.

Alcoholism Treatment In Prepaid Group Practice/Health Maintenance Organizations — Group Health Association of America, Washington, 1977. Selected papers compiled Feb 1977. Appendices include fact sheet and interview. 48p.

Drinking Patterns Among Adults In Western New York State: A Descriptive Analysis Of The Sociodemographic Correlates Of Drinking — Barnes, G. M., and Russell, Marcia, Research Institute on Alcoholism, Buffalo, 1977. Report of survey carried out in a large sample in Erie and Niagara counties: alcohol consumption, relationship to demographic and social factors. References, appendix-questionnaire. 103p.

Drugs, Crime And Politics — Trebach, A. S. (ed). Praeger, Toronto, 1978. Selected papers from the 1975 annual meeting of the American Society of Criminology, Toronto. Includes Everson and Segal on narcotic use in Toronto, Single and Kandel on the role of buying and selling illicit drug use. Erickson on cannabis prohibition. References. 197p. $23.40.

Adolescents And Alcohol — Hawker, Ann, B. Edsall, London, 1978. Report of an enquiry into adolescent drinking patterns carried out from Oct, 1975, to June, 1976. Appendices include additional tables, questionnaires, existing legislation in Great Britain, additional bibliography. Index. 65p. $12.

The Journal

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

Detox Training Program — April 3 — May 4, Toronto, Ontario. Information: Mr G. Gooding, assistant to the coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

Our Children Our Future — April 9-11, Toronto, Ontario. Information: Ontario Association of Children's Aid Societies, 663 Yonge St, Toronto, Ont, M4Y 2A4.

Family Therapy Workshop — May 5-6, Toronto, Ontario. Information: Dean Darnell Social Work Consultants Ltd, 235 Church St, Oakville, Ontario, L6J 1N4.

10th International Congress For Suicide Prevention and Crisis Intervention — June 17-20, Ottawa, Ontario. Information: Secretariat, IASP Congress '79, 700-71 Bank St, Ottawa, Ont, K1P 5N2.

70th Annual Conference Of The Canadian Public Health Association — June 18-22, Winnipeg, Manitoba. Information: Mr G. H. Dafoe, executive director, CPHA, 1335 Carling, Suite 210, Ottawa, Ontario, KIZ 8N8.

Input '79 — 3rd Biennial Canadian Conference On Occupational Alcoholism And Drug Abuse —Sept 23-26, Ottawa, Ontario. Information: Input '79 headquarters, Conference and Seminar Services, Humber College of Applied Arts and Technology, Box 1900, Rexdale, Ont, M9W 5L7.

Canada Safety Council's 11th Annual Safety Conference — Sept 30 — Oct 3, Quebec City. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario, K1G 3V4.

United States

4th Annual Southeastern Occupational Program Training Institute — April 2-6, Atlanta, Georgia. Information: Ed Pierce, department of Human Resources, Alcoholism and Drug Section, 618 Ponce De Leon Ave NE, Atlanta, Ga, 30308.

Substance Abuse And Human Sexuality — April 26-27, Cincinnati, Ohio. Information: Ann Blankenhorn, alcoholism consultant, Consultation and Education, 530 Maxwell Ave, Cincinnati, Oh, 45219.

American Medical Society On Alcoholism — April 26-May 2, Washington, DC. Information: J. G. Chen See, MD, AMSA, 733 Third Ave, New York, NY, 10017.

1979 National Alcoholism Forum and Annual Meeting Of The National Council On Alcoholism — April 27-May 2, Washington, DC. Information: National Council on Alcoholism, 733 Third Ave, New York, NY, 10017.

14th Meeting — Association of Halfway House Alcoholism Programs — June 3-7, Lincoln, Nebraska. Information: AHHAP, 786 East 7th St, St Paul, Minnesota, 55106.

The 41st Annual Scientific Meeting Of The Committee On Problems Of Drug Dependence, Inc — June 4-6, Philadelphia, Pennsylvania. Information: Dr Leo E. Hollister, Veterans Administration Hospital, 3801 Miranda Ave, Palo Alto, California, 94303.

6th Annual Puerto Rican Substance Abuse Conference — June 5-8, Santurce, Puerto Rico. Information: '79 Conference, National Association of Puerto Rican Drug Abuse Programs, 1766 Church St NW, Washington, DC, 20036.

Ohio Drug Studies Institute 1979 — June 11-15, Columbus, Oh. Information: ODSI Training, Division of Mental Health, 13th floor, Room 1346, 30 East Broad St, Columbus, Oh, 43215.

Southern Oregon Institute Of Alcohol Studies — June 17-22, Ashland, Oregon. Information: Ruthanne Lidman, coordinator, SOIAS, 3355 View Drive South, Salem, Or, 97302.

21st Annual International School Of Alcohol Studies — July 15-20, Grand Forks, North Dakota. Information: F. Wittmann, conference coordinator, University of North Dakota, Continuing Education, Box 8277, University Station, Grand Forks, ND, 58202.

Annual Summer Institute of Drug Dependence — July 29 — Aug 3, Colorado Springs, Colorado. Information: Summer Institute of Drug Dependence, PO Box 2172, Colorado Springs, Co, 80901.

6th National Drug Abuse Conference — Aug 26-30, New Orleans, Louisiana. Information: NDAC '79, 115 South Chestnut St, Lafayette, La, 70501.

30th Annual Meeting Of The Alcohol And Drug Problems Association Of North America (ADPA) — Aug 26-30, Washington, DC. Information: Driscoll and Associates, 1925 North Lynn St, Suite 1001, Arlington, Virginia.

4th World Conference Of Therapeutic Communities — Sept 16-21, New York City. Information: Charles Devlin, coordinator, Daytop Village, Inc, 54 West 40th St, New York, NY, 10018.

Association of Labor-Management Administrators And Consultants On Alcoholism (ALMACA) — Oct 2-6, Detroit, Michigan. Information: ALMACA, 1800 North Kent St, Suite 907, Arlington, Virginia, 22209.

National Conference On The Problems And Preventions Of PCP Abuse — Nov 3-4, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, Ca, 94117.

Abroad

International Conference On Animal Models In Alcohol Research — June 4-7, Helsinki, Finland. Information: John David Sinclair, Research Laboratories of the State Alcohol Monopoly (ALKO), Box 350, SF-00101, Helsinki 10, Finland.

The 6th World Congress Of Acupuncture — June 17-22, Paris, France. Information: Pierre Bidault de Villiers, Service Presse "Mondial", 3 Ruse de la Grande Truanderie, 75001 Paris, France.

4th World Conference On Smoking And Health — June 18-21, Stockholm, Sweden. Information: 4th World Conference on Smoking and Health, c/o RESO Congress Service, S-105 24, Stockholm, Sweden.

25th International Institute On The Prevention And Treatment Of Alcoholism — June 18-22, Tours, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

The 1st International Conference On First Aid At The Scene Of An Accident — June 19-23, Oslo, Norway. Information: The Norwegian Automobile Association, NAF, PO Box 494, N-Oslo 1, Norway.

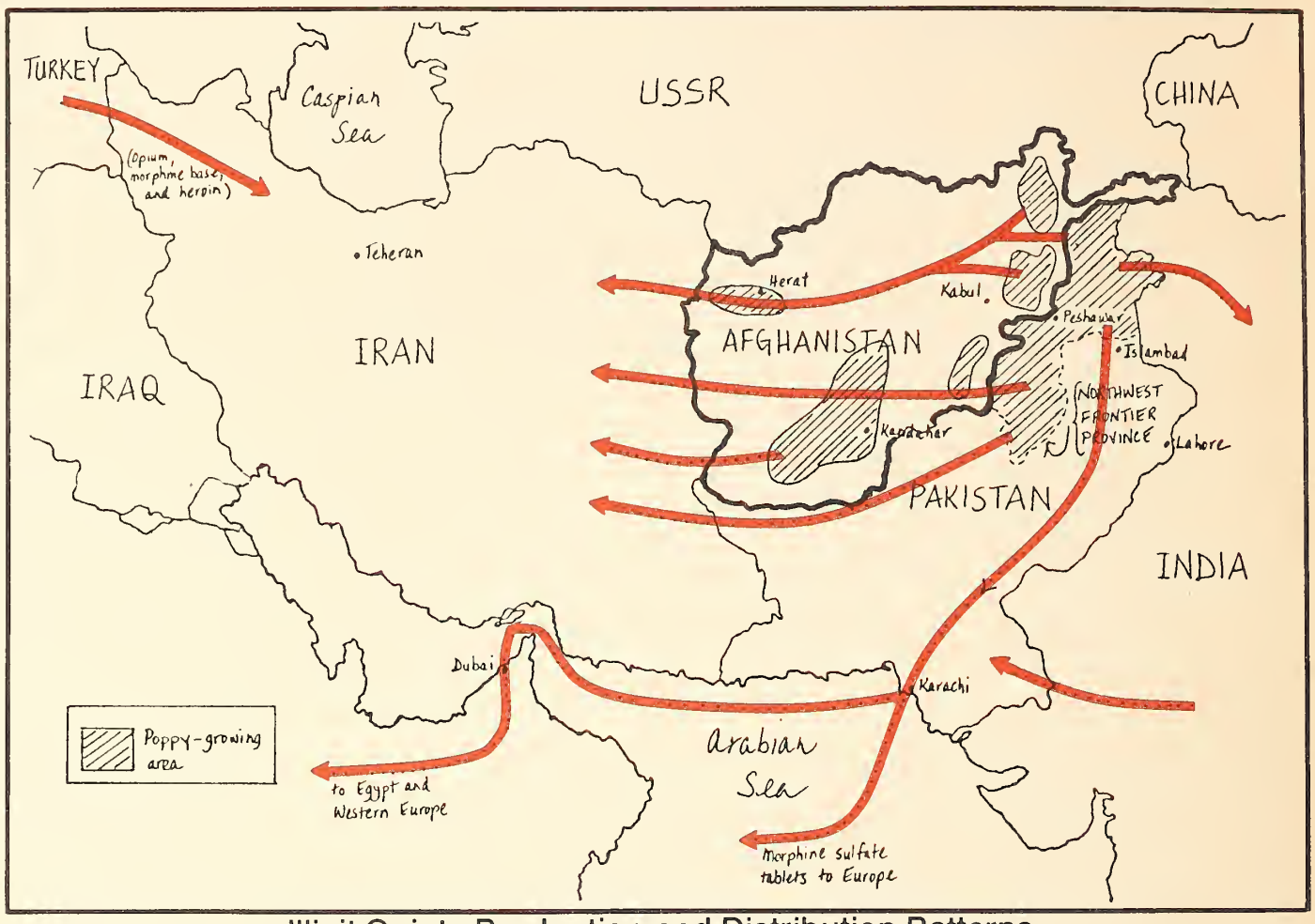
6th Institute On Drugs, Crime and Justice In England — July 3-20, London, Eng. Information: Arnold S. Trebach, director, Institute On Drugs, Crime and Justice in England, School of Justice, The American University, Washington, DC, 20016.

3rd World Congress Of The International Commission For The Prevention Of Alcoholism And Drug Dependency — Aug 26-31, Acapulco, Mexico. Information: ICAP executive director, 6830 Laurel St NW, Washington, DC, 20012.

AFGHANISTAN

Scene set for world heroin trade debut

By Robert Solomon*



Illicit Opiate Production and Distribution Patterns in Iran, Afghanistan, and Pakistan

Afghanistan's abundant opium harvests have become a matter of concern to European and North American enforcement officials. They fear that large quantities of Afghani opium processed domestically, or in Pakistan, will flow into the international heroin markets if substantial shortages result from the Southeast Asian and Mexican eradication programs.

These concerns are amply justified — morphine base and heroin laboratories have been established in both Afghanistan and Pakistan in the last five years; Pakistani traffickers are illicitly producing morphine sulfate tablets for distribution in Western Europe; and a 1977 United Nations report suggests that small quantities of heroin made from Afghani opium have appeared on the Western European black market.

Expansion of Afghanistan's opiate trade seems inevitable in the immediate future despite efforts that may be made by the present government. Although there has been recent progress, enforcement and customs programs are still inadequate, and corruption has been widespread. Opium remains a basic drug in rural medicine, and the government is unable to control many of the regions in which the poppy is grown and processed.

Afghanistan's changing role in international trade reflects fundamental shifts in the illicit trade of South Asia (Iran, Afghanistan, Pakistan, and India). Traditionally, several factors kept South Asian opiates out of the international black market: Illicit supplies of opiates matched illicit demand; almost all the opium diverted from licit cultivation in India was consumed domestically; and the opium produced illicitly in Afghanistan and Pakistan was consumed locally or smuggled into Iran. South Asia did not produce morphine base or heroin and there was little demand for opium gum in Europe or North America. There were few contacts between those involved in the South Asian market and the European and North American narcotics syndicates. Smuggling was impeded by the distances involved and the lack of commercial transportation networks.

Profits

Development of indigenous morphine base and heroin production, however, increased the markets for, and profits from, Afghani and Pakistani opiates, and reduced transporation problems. Because of its low morphine content, 13 to 15 kilograms of Afghani and Pakistani opium are required to produce the equivalent of one kilo of pure morphine base or heroin. Opium has a strong pungent odor and, depending on its consistency, can be extremely difficult to transport. Morphine base and heroin, on the other hand, are relatively odorless and may be stored in any watertight container. The trafficker's profit on 15 kilos of opium would probably be a fraction of his profit on a kilo of heroin or morphine base.

The influx of young Europeans and Americans into South Asia during the late 1960s and early 1970s, and the subsequent development of hashish-smuggling syndicates, eased the way for opiate smuggling. Criminal networks were soon established between South Asia and Western Europe and transportation facilities were greatly expanded.

Another major factor influencing the Pakistani, and particularly the Afghani opiate trade, is the Iranian market. Iran's decision to tighten border security and introduce capital punishment for narcotics smuggling in 1969 may have encouraged some Afghani and Pakistani traffickers to seek other markets or shift from opium to morphine base and heroin production — far more profitable and less risky enterprises. In spite of the severity of the Iranian law, the country's roughly 375,000 unregistered opium smokers and 50,000 heroin users remained the primary foreign market for Afghani and Pakistani opiates.

Increases

If Iranian demand remains stable and a shortage of heroin develops in Western Europe or North America, poppy cultivation and opiate processing will likely increase in Afghanistan and Pakistan. Although morphine base and heroin refining has only recently begun in Afghanistan, it will expand if there is a sustained crackdown on Pakistani laboratories.

Despite laws prohibiting the cultivation, sale, and possession of opium, the Afghani trade flourishes. American narcotics officials estimate Afghanistan now produces 290 metric tons of opium — nearly three times its estimated 1971 output. Most poppy cultivation areas are only nominally under the central government's control. The country is extremely poor and underdeveloped — in many regions opium is the farmers' sole cash crop. Since no other crop, with the possible exception of hashish, provides a comparable return per hectare, the opium farmers are unlikely to abandon poppy cultivation without resistance. Consequently, the government has been hesitant to enforce the ban on cultivation. Nor does it have the financial resources to undertake a comprehensive crop substitution program. Even if such a program was heavily subsidized by foreign sources, educating the farmers and transporting their crops to market would remain formidable problems. And local tribes might view such projects as unwarranted intrusions on their autonomy.

Meanwhile, addiction appears to be a growing problem. Opium is used to treat a variety of ailments, particularly in the remote regions which lack medical facilities. Unless medical services are expanded greatly, drug treatment programs are initiated in areas where addiction is most prevalent, and law enforcement efforts are increased, the situation cannot be improved.

Afghanistan, until recently, enforced neither its domestic narcotics laws nor its international narcotics agreements. For example, Afghanistan and Iran signed an agreement to improve border security in 1956, but Afghani border patrols were not strengthened until 1974. Similarly, Afghanistan prohibited opium poppy cultivation in 1957, but took no action to enforce the law in the traditional producing regions.

Enforcement

Drugs of all kinds were freely available, and Kabul, the capital, became a haven for North American and European drug users in the late 1960s and early 1970s. The domestic laws provided stiff penalties, but the few who were arrested, prosecuted, and convicted, were given light jail sentences or fines. The narcotics and border police were understaffed, poorly trained, poorly equipped, and underpaid. Corruption among police and government officials was widespread.

The ineffectiveness of Afghanistan's early enforcement efforts is best understood in the context of the country's history. Afghanistan was created in 1747 by the union of some minority groups and a number of Pathan tribes which had previously enjoyed semiautonomous status within the Persian Empire. The country remains, essentially, a loose confederation of tribes. Efforts to modernize the economy in the 1930s met with violent tribal resistance and the economy is still based almost exclusively on the barter system. Although the exact size of the population is unknown, it is estimated that one-fifth remains nomadic.

Much of Afghanistan is ruled by tribal leaders who are only nominally under the sovereignty of the central government. The border regions are inhabited by the Tadjiks and Kafirs, the country's second and third largest tribes. They resent Pathan domination of the country and might seize upon a strictly enforced opium ban as a cause for revolt.

Nevertheless, the government has shown increasing concern about the drug problem. In 1972, two ministerial-level committees were established to formulate narcotics control programs. The United States, West Germany, and the United Nations offered to provide financial assistance, but the Afghani government postponed consideration of the offers until it could develop a narcotic control plan with United Nations advisors.

Improvement

In 1974, Afghanistan signed an agreement with the United Nations Fund for Drug Abuse Control to provide advisors and funds to train and equip special narcotics enforcement teams. Afghani and UN officials also began discussions on the development of crop and income substitution programs. Denmark and the United States have provided additional funds to finance UN projects aimed at prevention and treatment of drug abuse, and more rigorous narcotics enforcement.

There have been noticeable improvements in domestic law enforcement: the amount of opium seized has risen sharply; Kabul is no longer a haven for foreign drug users; and sentences for drug offences are now heavier.

Mohammad Daud, who seized power in 1973, was far more willing to seek outside funding and commit government resources to curtailing the illicit trade than his predecessors. He initiated a number of economic and industrial projects to modernize the country, which would indirectly assist in developing income substitution programs and more effective narcotics enforcement.

The regime that overthrew the Daud government in a bloody coup in April, 1978, seems to have expanded the industrialization projects. However, it cannot yet be determined if the new regime views the curtailment of the illicit trade as a priority issue.

***Robert Solomon is an associate professor at the Faculty of Law, University of Western Ontario, London.** **This article is a revised version of a larger study entitled** *A Review of the Development and Present State of the Illicit International Heroin Trade.* **The study was partially funded by the then Non-Medical Use of Drugs Directorate of Canada's National Department of Health and Welfare.**

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The Journal

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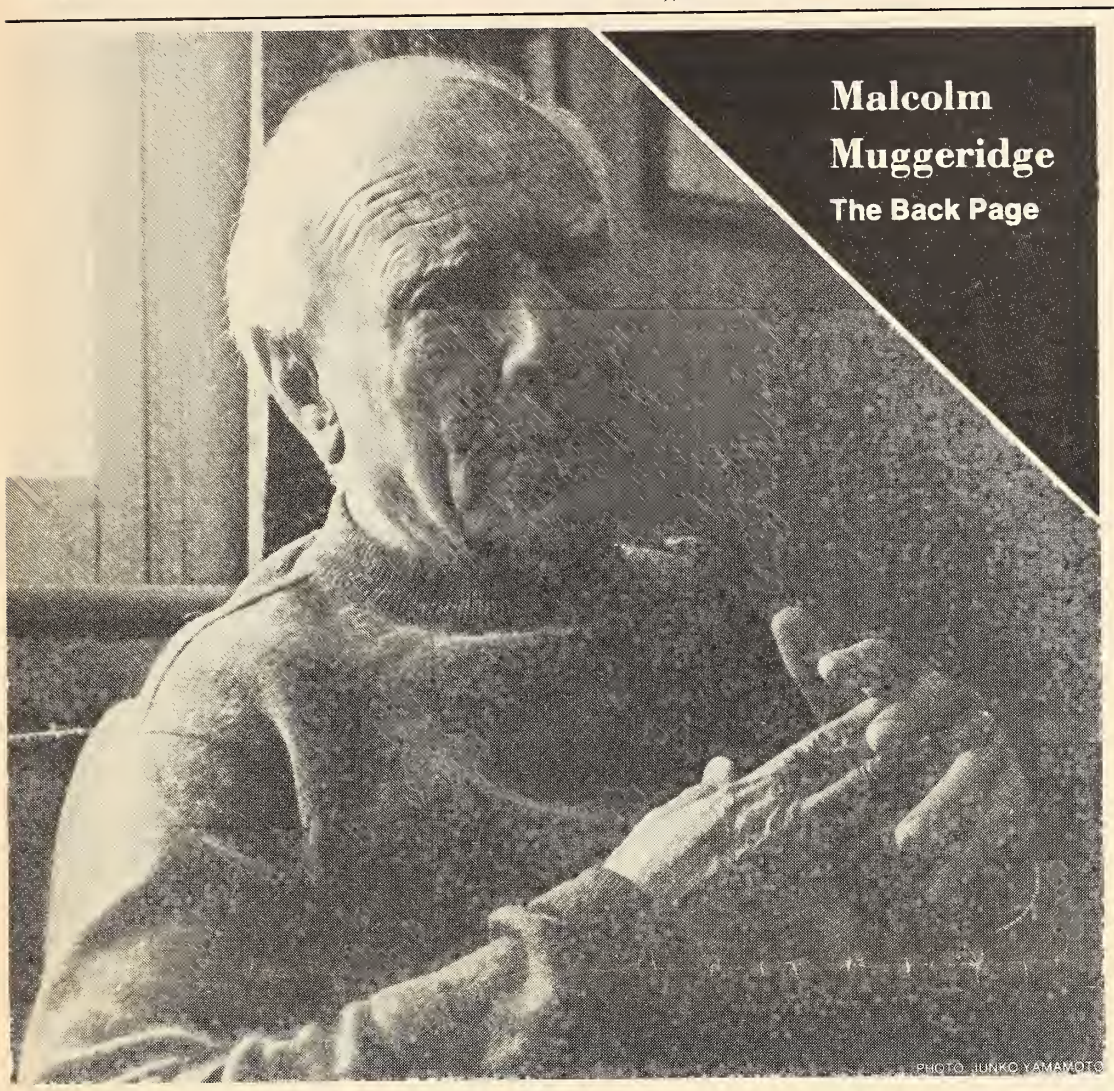

Teen pot use up in US: Report

WASHINGTON — There is an alarming upward trend in marijuana use by adolescent girls and boys in the United States although peak use remains in the 18- to 25-year-old group.

The latest government report on marijuana and health submitted to Congress says that between 1966 and 1977 the number of young people aged 12 to 17 who were current marijuana users had increased from 12.4% to 16.1%.

Among adolescents, two girls had used marijuana for every three boys. This is a far higher percentage than the one woman for every two men in those aged 18 years and older.

Joseph Califano, secretary of Health, Education and Welfare, says in the report: "It is sheer folly for millions of young Americans to indulge in a drug when so little is known about the long term consequences."

The report said that among 12- and 13-year-old children, 8% had reported some experience with marijuana and 4% said they were current users. In those aged 14 and 15, some experience was reported by 29% and 15% said they were current users.

Some 47% of those aged 16 and 17 reported some experience and 29% said they were current users. The highest rates were in those aged 18 to 25: 62% reported some experience of the drug and 31% said they were current users.

■ More next month ■

DeLuca appointed NIAAA director

WASHINGTON — John DeLuca, former director of the division of Alcoholism and Alcohol Abuse for the State of New York, has been appointed director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

His appointment by Joseph Califano, secretary of Health, Education and Welfare, brings to an end a search which has gone on for nearly a year and has been marked by controversy and criticism.

Mr Califano said Mr DeLuca, 35, "is a skilled administrator who will provide the institute with strong new management and leadership.

"His administrative experience, analytical ability, and his record of strong support for scientific research, makes him an excellent choice to lead the federal effort to combat this major health and social problem."

Observers believe Mr DeLuca's appointment will prove popular with many administrators in the field because of his state agency background. The appointment also breaks tradition: until now the NIAAA director has been a medical doctor.

Mr DeLuca takes over from Lorne Archer, who was appointed acting director when Mr Califano forced Dr Ernest Noble to vacate the post.

Drying out with the handicapped

By Tim Padmore

VANCOUVER — "Hi, man!" The greeting, offered in childish innocence by a shambling 30-year-old man, is disconcerting.

The scene is Woodlands, a school for the retarded serving Lower Mainland, British Columbia. It's also the scene of a new provincial detox centre.

What's the effect on a drying out alcoholic of an encounter like that? Disconcerting, yes. But also, to everyone's surprise, often profoundly therapeutic.

Heroin isn't BC's No. 1 drug problem . . . Page 3

"A lot of our clients never really thought about themselves in relation to other handicapped people," said Pat Gilchrist, administrator of the unit. "They say, 'It makes me realize how lucky I am, and how I'm throwing away the things I have while they're working so hard.' "

The detox unit is in a renovated dormitrory, left vacant when enrolment in Woodlands declined as part of a move to community living for the retarded.

It is part of a network of facilities set up in the last three years by the Alcohol and Drug Commission of BC to fill gaps in the alcohol treatment systems.

Ms Gilchrist said there were worries when the 20-bed detox unit opened in December, 1977, that there would be problems with alcoholics teasing the retarded people.

Not only have the problems never arisen, but there has been the therapeutic bonus.

The unit is brightly painted, with individual rooms, a lounge, and a dining room that serves "really excellent" food.

The clientele is 75% male, 25% female, with a range of socio-economic types, from successful professionals to the unskilled unemployed.

During a four or five-day stay, treatment consists of drying out, good food, lots of rest, and warm baths (instead of drugs) to calm jangled nerves.

The centre takes people intoxicated on drugs other than alcohol, but booze is the problem in 98% of the cases.

Usually people come in on their own, although the self-referral is often precipitated by a family or job crisis, Ms Gilchrist said.

"We encourage the clients to keep regular contact with the family and encourage the family and employer to come visit them while they're here."

About 60% are referred on to other agencies after drying out, and about two-thirds of those actually keep the appointments, she said.

Drinking, walking don't mix: TIRF

OTTAWA — Drinking and walking don't mix, especially on weekends for men between 30 and 50 years of age.

According to the results of a Traffic Injury Research Foundation (TIRF) study entitled Alcohol Involvement in Pedestrian Fatalities, more than 30% of pedestrian victims of all ages tested for signs of alcohol in their blood, had been drinking. The percentage of drinkers jumped to 60% for the age group 30 to 50 years, and 84% of these were legally drunk, that is with a blood alcohol level of more than 0.08%.

The study involved 734 pedestrian accident victims. And while only 69.6% were actually tested for alcohol in their blood, the results are probably representative for the whole group since the large majority (more than 76%) of all age groups, except those from one to 14 years, were tested. Only 19.3% of this lowest age group were tested for alcohol with only four of the 32 found to have been drinking with none legally impaired.

Several interesting factors emerged from the study, including the fact all adult groups had significant percentages of drinkers: 40% for those 15 to 29 years, 60% for those 30 to 50, 41% for those 51 to 64, and 21% for the 65 and older group.

The degree of impairment was highest in the 30 to 50 age group with more than half the drinkers having blood alcohol levels of 0.2% or greater.

And for the drunk pedestrian victims, weekends were the most dangerous. Twenty-five percent of the accidents happened on Saturdays, 19.5% on Fridays, and 18.9% on Sundays.

Based on an evaluation of 17 different attributes, the TIRF study produced the following profile of a typical impaired pedestrian victim; more often male, 30 to 50 years of age, usually an unskilled worker, with the accident usually occurring on the weekend, almost always at night, and under clear weather conditions. The victim is either walking or lying on a straight road, hit by an automobile travelling straight ahead, and with the driver usually absolved of blame.

The study illustrates alcohol is not the only major factor at work. Age is also important with more victims in the lowest and highest age groups.

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'Hands off' in alcoholism therapy

By Donald Gregory Bastian

TORONTO — Dr Griffith Edwards of London's Maudsley Hospital says that in treating alcoholics, less intensive treatment may be more effective than extensive intervention.

Speaking to reserarchers and administrative staff of the Addiction Research Foundation here, Dr Edwards said two decades of alcoholism treatment research have led to this "negative but honorable finding."

He criticized alcoholism treatment research for its uncontrolled experimentation and failure to study the effects of "treaters" on patients, regardless of the type of treatment used.

This failure has led to the mistaken assumption that more is better in alcoholism treatment, he said.

Dr Edwards, director of the alcoholism research unit at the Maudsley, said the importance of the attitudes of social workers and medical personnel was missed by Rand researchers when they concluded in a recent study that it didn't matter so much *what* treatment was given to alcoholics, as long as they got *more* treatment.

"The system invites people to stay; the treaters give reinforcing smiles to patients who are doing better and glaring disdain to those less well, or who would dare to leave treatment early."

Dr Edwards' own research has led him to the position that "the treatment moment is a moment of change, whether that moment be long or short, or in or out of hospital." (Dr Edwards holds the only chair in addiction studies in the world, as professor of addiction behavior at London University.)

"It is very mysterious that people who come through the doors of treatment, whatever happens, will 12 months later have been found to have changed their behavior."

This mystery, he said, is intimately tied to the mystery of the "natural processes" by which alcoholics treat themselves and "modify their own behavior.

"We say to the person who decides to attack his drinking by starting a new job or moving to a new town that he is just running away from his real problem, but maybe this is a part of natural processes by which people take care of their own problems."

It is difficult to pin these processes down scientifically, he said, but the social worker's sense of them should be something like that of a surgeon who understands instinctively the healing processes that follow surgery.

Continuing his "less may be better" theme, Dr Edwards said social workers and doctors should perhaps "take their hands off a bit, edging in a little and just helping the natural process, rather than insulating the possibility of that person's directing himself toward a cure."

He warned that this demands a certain humility on the social worker's and doctor's part, as well as a rethinking of roles in the treatment process.

In moving toward a "minimal treatment," Dr Edwards said, treaters should:

Griffith Edwards

- Become better listeners, asking what the patients think of the treatment they are undergoing.
- Realize patients are reliable, intelligent informants who could contribute to research.
- Stop treating patients as passive recipients of treatment.
- Assess the consequences for individuals of the partnership between therapist and patient.
- Determine the best way of monitoring a patient's progress beyond direct treatment.

Study hits sleeping pill RXs

WASHINGTON — Most of the prescriptions for sleeping pills written each year for an estimated 8.5 million Americans are not justified on medical grounds, according to a report by the National Academy of Sciences.

A study by a committee from the Academy's Institute of Medicine said that while sleeping pills have a place in clinical medicine and doctors have changed their prescribing patterns over the past eight years, it is still difficult to justify most current use.

In 1971, doctors wrote 41.7 million prescriptions for sleeping pills. By 1977 the number of prescriptions issued had dropped to 25.6 million.

There has also been a change in drugs prescribed: barbiturates, which were once a most popular compound, have been surpassed in popularity by benzodiazepines. Fifty-three per cent of all sleeping pills prescribed in 1977 were for flurazepam (Dalmane), a member of the benzodiazepine family.

The committee said the doctor should keep their prescriptions "to a very limited number of pills for use for a few nights at a time." In only rare instances should prescriptions be given for more than a two- to four-week supply of pills.

The beneficial effects of sleeping pills "is typically to reduce the time needed to fall asleep by 10 to 20 minutes and to lengthen the night's total sleep time by 20 to 40 minutes."

Doctors should warn patients about possible dangers from sleeping pills especially if used in conjunction with alcohol, the committee said. Patients should also be warned that some compounds linger in the body and after a period of use the patients run the risk of becoming too drowsy to drive a car or operate machinery in a safe manner.

CBC'er heads AFM

WINNIPEG — David Cruickshank, managing director of Canadian Broadcasting Corporation (CBC) radio for Manitoba, has been appointed managing director of the Alcoholism Foundation of Manitoba (AFM) by the Manitoba government.

Mr Cruickshank succeeds James Toal, who took over as interim director on the recent retirement of R. S. Graham.

A native of Edmonton, Mr Cruickshank has worked in broadcasting for the past 33 years. During the early 1950s, he worked as an assistant to the director of the Alberta Alcohol Foundation in education and public information and later in the development of the Saskatchewan Bureau of Alcoholism. He has continued active work in the alcoholism treatment field as a lay counsellor.

The new managing director assumed his duties at the AFM on May 1.

Daily drinking OK in the 'safe zone'

EASTBOURNE — Dependence on alcohol, like dependence on tea or coffee, is not necessarily harmful, a doctor specializing in alcoholism told a conference today.

"There is nothing wrong, medically or socially, in dependence on a licit drug. The ordinary man likes his drink and, indeed, his life would be the poorer without it," David Davies, medical director of the Alcohol Education Centre, told the Royal Society of Health's congress at Eastbourne.

Drinkers did not become alcoholics until they downed 10 shots of spirits, five to six pints of beer, or 1 bottle of wine a day, he said.

"There is a safe zone of drinking, even of daily drinking," said Dr Davies, who is also medical director of the Newington Alcoholism Unit in London.

But he warned that the drinker must monitor his intake because he was safe only so long as his consumption did not approach the threshold for alcoholism.

At the Farmwood they kick Medical Model

By Wayne Howell

Farmington Oaks was once the country retreat of a wealthy eccentric but now this stately old mansion surrounded by verdant southern Ontario countryside is the home of the Farmwood Institute, a unique treatment and rehabilitation centre. Recently I visited the Farmwood Institute and spoke with the director.

"What type of person comes to Farmwood?" I asked him, after we had settled into comfortable chairs in the handsome panelled library.

"The most eminent physicians, the most prominent health administrators, the most humble lay-volunteers — all are welcome," he replied.

"Could you tell the readers of **The Journal** exactly how your program works?"

"We have developed a three phase program. Phase I involves the taking of a comprehensive concept-history: we find out exactly when they first started to think of alcoholism as a disease — how long they've been hooked on the Medical Model in other words. If it turns out that their habit is not deeply-rooted we put them right into Phase II. But if they've been doing Medical Model heavily or for a prolonged period we can't rush them right into Phase II, we have to let them withdraw slowly.

"Usually we prescribe some light reading — Dr Thomas Szasz or something like that — and in a week or so they're ready for Phase II. Of course we lose some in Phase I, I won't deny it. But we're philosophical about it — either a person is ready for a drastic change in his thought-style or he isn't; you can't force people."

"What happens in Phase II?" I asked.

"Basically Phase II involves individual counselling and instruction. Our therapists point out the deficiencies of the Medical Model. For instance, we show them the results of studies like the one done at Maudsley Hospital in London . . . ."

"That was the study that showed simply telling alcoholics to stop drinking was just as effective as a whole variety of Medical Model treatments such as psychiatric counselling, drugs, Alcoholics Anonymous, admission to hospital, etc. . . ."

"Right. And then we confront them with the Ledermann hypothesis: we show them that the proportion of a population drinking excessively is largely determined by the average consumption of that population, and we prove it with charts and graphs. From there it is usually easy for them to accept that the alcohol problem is basically a political rather than a medical problem, for only society as a whole can decide how much suffering (in the form of alcoholism) it is prepared to tolerate for the sake of how much happiness (in the form of inexpensive alcoholic beverages) it feels it must have. But if we meet resistance at this point . . . ."

"Resistance — what kind of resistance?"

"You must realize that people who have been doing Medical Model for years are very dependent upon it. In many cases there is an actual physical dependency, because Medical Model justifies well-paying jobs in various treatment services. And in all cases dependency is psychological because the Medical Model embodies assumptions that are convenient for everyone; it allows people to feel no guilt about the effect their own consumption of alcohol might be having on others, and it allows politicians — and persons advising them — to avoid making unpopular decisions.

"Don't kid yourself — it's not easy to discard the Medical Model if you've been hooked on it for years. Phase II is a tough time and that is one of the reasons why we restrict our clients to the grounds of the estate during Phase II."

"Can they have any contact with the outside world?"

"We do allow them to have visitors, although we monitor that kind of activity very closely. You'd be surprised how many colleagues and friends try to smuggle things in — books by E. M. Jellinek, AA literature, stuff like that. Just last week we caught one of our clients — who had been coming along very nicely — out behind the carriage house knocking back a hardcover volume of *The Disease Concept of Alcoholism*. A visitor had slipped it to him disguised as *The Brothers Karamazov*."

"What happens after Phase II?" I asked.

"Phase III is a re-working of the concepts learned in Phase II in a group setting: the group performs a supportive and ego-building function. They need that, since they're still pretty shaky because of all the dearly held notions they had to give up back in Phase II. Phase III is also the testing period: they are allowed out on weekend passes. They can go back and consort with their peers in the foundations, treatment centres, hospitals, and bureaucracies from whence they came."

"Isn't that risky — because of the influence of the peer group?"

"Of course it is. But they can't spend their whole lives at the Farmwood Institute. They've got to see if they can hack it in the real world without Medical Model sometime. And that moment comes when they graduate from Phase III."

"What happens then — I'm curious about your recovery rate?" The director took a moment to answer.

"I'm not going to try to kid you — a lot of them slip back into Medical Model thinking as soon as they hit the streets. Everyone hooked on the Medical Model has a deep-rooted craving for it; in many cases they cannot function without it, for where would their jobs be otherwise?"

"Do you ever feel that your task is hopeless?" I asked.

"Sometimes," he said with resignation. "I think it's easier for a camel to pass through the eye of a needle than for the head honcho of a richly endowed treatment program to doubt the validity of the Medical Model."

BC's scrutiny could shift to alcohol

By Tim Padmore

VANCOUVER — If you counted headlines, you would conclude that British Columbia's heroin problem is much more important than any other addiction problem.

Of course, that isn't true. As elsewhere, alcohol is number one here.

And despite the fact that the provincial budget for treating alcoholism is dwarfed by the support being given the controversial attack on heroin, solid progress has been made in providing quality alcohol treatment for all areas of the province.

In fact, the alcohol program of the Alcohol and Drug Commission is in such sound shape, and the heroin program so unsteady in the gales of controversy, that there is serious talk, both within and outside the commission, of turning the vast resources of the heroin arm to the larger alcohol problem.

That talk has sparked both hope and panic among alcoholism workers. Hope of a really important attack on the problems — and fear that existing community-based agencies will be pushed aside as the commission expands its own programs with leftover heroin therapists.

The Journal talked to Carl Stroh, director of non-narcotic services for the commission, about these questions.

First of all, he said, there is no danger of a glut of addiction therapists should the heroin plan collapse.

"If there was no longer a heroin treatment program, we would not have an oversupply of counsellors and therapists to deal with the problems of alcoholism and multi-drug abuse. All our services are booked to the teeth (even though most) people aren't aware of our services."

The commission has a commitment to community-based agencies and currently runs directly only a few outpatient clinics and detox centres, while supporting about 50 outside agencies.

That number is down from about 80 a few years back, but the contraction resulted from an effort to rationalize an uncoordinated system, he said.

What the commission has done is set up a basic spectrum of services in each of four major divisions of the province.

That spectrum includes at least one detoxification centre, a residential treatment program, outpatient counselling clinics, and long term support in halfway houses. "Something," Mr Stroh said, "in every community."

The idea was to put services where they were needed instead of allowing them to spring up in response to political or other local pressures.

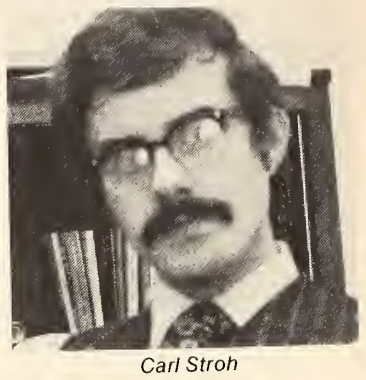
The three-year program of reorganization and construction is pretty well finished. "Our basic concern now is upgrading this system."

Units are more specialized now, which encourages cooperation and avoids duplication of services, he said, although there is the disadvantage that clients may get an assembly-line feeling as they are referred from place to place.

The major undertaking this year, Mr Stroh said, is a computerized information system to keep track of clients and the treatments they receive at the different centres. It is being set up at the request of "treatment people, not commission bureaucrats," he emphasized.

The budget for non-narcotic services will be a little more than $5 million, compared to about $9 million for the heroin plan, which will be hiring 252 full-time and 111 consulting staff.

The support being lavished on the heroin side has offended



Carl Stroh

some alcoholism workers and frightened others with the vision of squadrons of idle and undismissable therapists looking for greener pastures.

All addictions offer a common problem, acknowledged Mr Stroh, the basic question being: What is it about society that creates people who are addiction prone?

And it's a question, he said that can challenge armies of experts.

Chinese warned of tobacco's dangers

By Lachlan MacQuarrie

HONG KONG — Amid the trends in China toward increasingly free and open expression of opinion in wall posters and newspapers has come China's first public recognition of the physiological dangers of smoking tobacco.

The *Kwanming Daily*, a newspaper from the prefectural city of Yunnan Province in southwestern China, recently carried an article signed by three doctors calling upon young people to cut tobacco consumption, and upon parents and schools to launch anti-smoking education programs.

The Kwanming article lays some of the blame for an increasing use of tobacco by young people on the disgraced "gang of four," and accuses them of failing to protect the health of China's youth.

However, though China is thought to be one of the very few countries where narcotics abuse has been eliminated, the nation faces a different kind of challenge if it is to tackle the health problems of smoking. China's patterns of tobacco production and consumption will not be easy to change, especially since they bear so significantly on tax revenue and export markets.

It may not generally be recognized that China produces the world's largest tobacco crop. Over the past five years, China's tobacco production has averaged more than 9 million metric tons per year. The United States, with the world's second largest tobacco crop, has averaged 8.5 million metric tons annually over the same period, while third-placed India's average has been about 4 million tons.

Clearly, therefore, tobacco crops and cigarette production are major factors in the economy of several geographical areas of China. Many communes and production brigades in the provinces of Yunnan, Kwangsi, Kwangtung, Fukien, Kiangsi and Hunan, all in the southern and coastal regions of China, are in some measure dependent on tobacco. Even in the more northern Kansu Province, tobacco is grown and processed.

Not only is tobacco an important element in agriculture and industry, but, in addition, the tax on cigarette sales provides a major source of investment capital for the Chinese government. Also extremely important at a time when China is seeking outside resources to assist with technological development is the fact that the sales of tobacco products abroad represents an important source of all-too-scarce foreign exchange.

Thus, China is seeking to expand sales of tobacco products, especially in areas of South-East Asia such as the Philippines, Singapore, and Hong Kong. In Hong Kong the Chinese government-controlled department stores offer for sale many varieties of cigarettes, cigars, and other tobacco products under such brand names as "Double Happiness," "Winner," "Star Lake Menthol Cigarettes," and "Great Wall Cigars."

Some brands are even advertised as having medicinal uses and other special properties. A small package of "Sailing Boat Herb Cigarettes" contains five cigarettes which are said to be effective in "allaying asthma and relieving cough."

A brand of Ginseng cigarettes is manufactured at the Changchun Cigarette Factory in northeastern China near the Korean border. Ginseng, long valued by the Chinese as a drug, is thought to have restorative powers for the aged and impotent, and is widely used for most diseases and informities and as an aphrodisiac.

Several brands of cigarettes and a brand of pipe tobacco are advertised as containing an extract of the herb *Ling Zhi* (or *Lingchi*). This herb comes from a fungus which is said to have "supernatural powers."

Anti-smoking campaigns, therefore, will face severe difficulties. They could even strike the Chinese people as hypocritical since many of their leaders, including the dynamic Vice Premier Ten Hsaio-ping, are smokers. The late Chairman Mao was an extremely heavy smoker.

PHOTO S. WONG

Bylaw would restrict solvent, glue sales

WINNIPEG — Winnipeg city officials are preparing a bylaw and enforcement regulations to control and restrict the sale of about 200 products and substances which can be inhaled by youngsters who want to achieve euphoric states by sniffing them.

The action comes after the civic recreation and social services committee of Winnipeg city council ordered the bylaw drafted despite warnings from advisors that a law restricting the sale of such things as solvent and glue would be impossible to enforce and could turn children to even more dangerous products, such as gasoline, for their kicks.

The bylaw would specify which products may be sold to children under 18 years and how merchants may market the potentially harmful products.

Substances such as contact cement, solvent cleaners, nail polish and nail polish remover, paints, and lacquers are to be included in the ordinance. Medical experts have warned that the products are being abused by children and that liver and kidney damage, nosebleeds, weight loss, and depression can result from sniffing them.

The action now to be taken is partly in response to a petition earlier this year from the Anti-Sniff Coalition, a group of Winnipeg core area social agency representatives.

Travellers breathing easier

LONDON — British non smoking adults are slowly becoming aware they are in the majority. Increasingly they are demanding "rights" for the non smoker, including smoke-free areas in public places such as restaurants, cinemas, and transport vehicles.

One of their champions, Laurie Pavitt, MP, reflected this newfound confidence just before the British general election, when he asked Health and Social Services Secretary David Ennals how far he had achieved results "in connection with the government's aim of increasing the provision for non smokers in public places."

Mr Ennals, a non smoker, said British Rail was planning to increase no smoking accommodation on both Inter-City and local trains. And he said London Transport (which runs the London underground railway system and the famous red double-decker buses) had announced that it was considering a complete smoking ban on its services.

The social services secretary also said that one major airline had recently extended facilities for non smokers while others were considering similar moves.

In restaurants and catering establishments, there had been a marked increase in the provision for non smokers while the great majority of London theatres now ban smoking.

Other "sources" in favor of the non smoker were two major banks which were discouraging smoking in public places and restrictions on smoking in some areas by the National Coal Board and the Association of District Councils. A spokesperson for the British anti smoking pressure group ASH said it chose Ash Wednesday (February 28) to press for more smoke-free areas in offices and other places of work.

He said the group had written to the Confederation of British Industry to point out how much discomfort and irritation was created by smoking at work.

The CBI was urged to recommend a policy under which non smokers could be offered a right to work in smoke-free areas.

'Addicts seldom leave cured'

PALMERSTON NORTH, NZ — Young people who attend methadone maintenance programs theoretically should be committing less crime — and this, in the view of Roger Ridley-Smith, can be guessed to be "the principal, possibly the only, benefit."

Methadone clinics "have no other function, but we could probably do with a few more clinics while we prepare for other solutions," he told a meeting here on chemical dependency.

Dr Ridley-Smith, medical officer at the society's Wellington drug clinic, said no attempt had been made to sum up the results of its methadone maintenance program.

"If there were any results worth analyzing, they would be hard to secure. Follow-up of patients is just about impossible. Most overseas work is valueless and the better studies have demanded a lot of painstaking research."

Reduction of methadone dosage is a worthwhile goal, he added, "but addicts seldom leave a clinic cured and most of us are reconciled to seeing and treating addicts for as long as they feel inclined to come."

Alcoholism: beneath the iceberg's tip

Reesa Kassirer focuses on the alcoholic's family system

By John Shaughnessy

TORONTO — To treat an alcoholic alone or to treat only his or her drinking problem is like viewing the top of an iceberg and ignoring the part below the water line.

"If you only look at one segment, you are only seeing part of a system. The part that's above water has many more facets beneath and can't be fully understood unless it's seen as part of a larger whole," says Reesa Kassirer, a social worker and family therapist with the Addiction Research Foundation of Ontario.

Mrs Kassirer says any treatment approach that classifies one person as the patient (the identified patient or IP) takes the person out of context and reinforces, for that person and his or her family, that this is the sick one, the bad one. "It negates the fact that the rest of the family or other half of the marital pair plays any role, and does a disservice to the client and the family."

Very often, for instance, a wife will declaim any part in her husband's drinking because she claims he was drinking before they got together. Mrs Kassirer believes such a claim distorts the true situation.

"When a person gets married or establishes a significant relationship, he or she chooses a person whose emotional patterns are 'familiar' — a person who fits needs and patterns."

The woman may, in fact, have chosen the man with a drinking problem because the patterns "fit." She may have "learned" from her own family of origin that she has to save the person she is intimate with, or be responsible for him, or make him happy. She will choose, as her significant other, someone she perceives as needing her, so she can relate in the emotional pattern she was taught.

The drinking husband, on the other hand, may have been "taught" in his family of origin that he does not know how to take responsibility for his own actions. Very often, he is not in touch with his feelings and believes he can only "feel" through someone else.

According to Mrs Kassirer, as children enter such a system, they too take places and positions that "fit" into the whole. If the marital relationship is such that the partners need supporting, or bolstering, or do not know how to nurture themselves or their partner, the children will learn at a very early age how to fill in some of the gaps, how to relate in a way that helps them survive. Often, this is at a cost to their own emotional growth and individualization.

The first job for the therapist working with a family with an addiction problem is to have the family understand the problem isn't just the "identified patient." Everyone is part of it, involved in it, and hurting.

"It's the pain that I address myself to, because even though many deny it, everyone is feeling it," said Mrs Kassirer. "Maybe I cannot resolve all of the issues, but I can help them modify some of the pain. The goal, as I see it, is to help people cope with their problems in a different way than the one they were taught, and to open up options for a richer life."

It's often been said alcoholics hate liquor, but they hate life more. "I don't know that they hate life more," said Mrs Kassirer. "It's how they experience their gut — the feelings they have when they're not drinking. They have not been taught how to tolerate uncomfortable feelings and usually have been taught not even to experience many of their feelings.

"Alcoholism, for me, is a learned process — one option many people take to help them feel better about themselves. Anxiety is lessened temporarily, and the person feels OK temporarily by using a substance to help him or her cover over the 'tender parts'.

"Very soon, those we work with use the substance to such a degree that they get into a stuck position and are not usually able, without assistance, to open up other possibilities for their functioning."

If someone has a drinking problem, Mrs Kassirer believes several areas must be looked at — the patient's level of self-esteem, how he feels about himself; how he communicates; the ways he's been taught to communicate; the statements he makes about himself, and how this becomes translated inside himself and, then, into behavior.

"You also have to look at the rules, the

extremely strong learned behavior, that he operates in, as well as what's happening in the outside world.

"If someone comes to me and is drinking too much because of stress at work, I can't change a boss who doesn't know how to be a boss," said Mrs Kassirer. "But I can help the employee who has come to me to cope with feelings, to understand them, so if there's no option for changing jobs, and the employee is doing as good a job as possible, he has no reason to feel he's the bad one. My goal is to ensure that the employee's self-esteem remains intact."

Mrs Kassirer concedes that family therapy, or the systems approach, is not *the answer* for alcoholics. "Nothing works all the time, and nothing works for everybody," she said. "There are many ways of treating alcoholics, but some way or another, and some time or another, you have to deal with the patient's system."

Russian women abusing alcohol at alarming rate say reports from USSR

By John Dornberg

MUNICH — Alcohol abuse among women in the USSR is increasing "alarmingly," according to recent reports in the Soviet press.

The ratio of female alcoholics to male is one to 10, according to Boris Levin, a Moscow researcher, a smaller figure than in the US, Great Britain, France or Switzerland.

"But that is little cause for comfort," said Levin in a lengthy article in the weekly *Literaturnaya Gazeta*, "because there is an alarming trend. The rate of increase in female alcoholism is higher than in men. Many cities have had to open women's sections in their sobering-up stations and psychiatric hospitals."

Before the 1917 revolution, according to Dr Levin, "laundry women, prostitutes, beggars, and domestics were the females most susceptible to alcoholism."

Those occupations and classes, he said, "no longer exist."

Today, the labor status of most of the women who abuse alcohol is semi-skilled and unskilled.

"The percentage of women in the services sphere and those who are non-working housewives is disproportionately great."

Alcohol abuse, according to Levin, is also very high among widows, divorcees, and single women. In 1966 they represented 40% of the women taken to sobering-up stations in the USSR. Last year they accounted for 50%.

"It seems," says Dr Levin, "that for a woman, a single existence is to some extent conducive to intemperate use of alcohol."

Family men are represented much more widely at sobering up stations than family women are, leading Dr Levin to conclude that family ties protect women from alcohol abuse more than they do men.

He reported on a survey conducted in various parts of the Soviet Union to ascertain female drinking habits.

More than 50% spend less than 5 rubles (approx. US $7) per month on wine and hard liquor, and nearly 25% between 5 and 10 rubles. Some 16% did not reply to the expenditure question in the survey.

Forty per cent use alcoholic beverages rarely, almost 50% only on holidays. Ten per cent did not reply.

More than half prefer to drink wine, 22% vodka.

Some 55% said they drank less than 100 grams (alcohol in the USSR is sold and measured by the gram) at one time, 25% between 100 and 200 grams, 5% between 200 and 300 grams. Again, 15% did not reply to the question.

More than half of the women surveyed said they drink in a group, 10% because "others around me do," 3% to "get along with people more easily," another 3% "for lack of anything else to do," and 4% for the "pleasant sensation they get from alcohol." But 10% refused to answer.

Dr Levin sees little cause for concern in the figures, but he did express worry about the large proportion of women who did not answer certain questions.

"When 10 to 15% of those surveyed refuse to answer some of the most ticklish questions," he reported, "it makes you wonder."

The replies to some other questions disturbed him, too.

Nearly all those surveyed had been "well acquainted" with alcohol by the time they were 20 years old. Only 10% considered it "unnecessary to offer guests alcoholic beverages." The rest all said they could not be good hostesses without offering alcohol.

When asked which alcoholic beverage they considered best to offer, 80% said vodka, cognac and wine.

Soviet women start using alcohol regularly later than men do, but they progress to alcoholism and alcohol abuse faster.

Brewers join war on alcohol

By John Dornberg

BONN — The brewery industry may seem like the last to warn people against excessive drinking, but in West Germany it is really happening.

The German Brewery League (Deutscher Brauer Bund) is to spend DM 700,000 (US $378,000) this year — almost half of its DM 1.5 million ($811,000) public relations budget .. on an advertising campaign designed to combat alcohol abuse.

Through Infoplan, an advertising agency here, it is distributing posters and brochures to 64,000 taverns and restaurants explaining in comics style which alcoholic beverages may be sold, and starting at which age, to young people.

The campaign also includes full page ads in various youth magazines such as *Bravo*, *Sounds* and *Popfoto*, warning young readers against resorting to beer and other alcoholic beverages as a means to deal with personal problems, such as difficulties in school or at work, conflicts with parents, or trouble making friends.

The magazines have a combined circulation of 12 million and it has been estimated that 80% of all West German youths aged 15 to 17, and 70% of those between 12 and 21 were reached.

Another campaign is also directed against adult problem drinkers.

It uses posters and magazine insertions as well.

"Beer quenches thirst but doesn't drown sorrows," says one such ad. "No one has ever succeeded at swallowing sorrows with beer. That's not what it's for. Beer is there to enjoy, to toast with friends, to add life to the party, and to make a good meal better — to your health!"

"Of course alcohol abuse is a problem," says Hans-Joachim Wulf, the president of the brewery league. "We felt that instead of just talking about it, it was time to do something, especially to combat it among youth."

The league was founded less than two years ago and is supported by contributions from West Germany's 1,500 breweries (of which 1,000 are in Bavaria).

There was initial resistance among members to the ad campaign because, as Wulf puts it, "we think of beer as a food product, not alcohol here."

But, he added, "ultimately the majority recognized that rising figures of teenage alcohol abuse could no longer be ignored or belittled."

NORML-Canada founder gets three months in jail

VANCOUVER — The founder of NORML-Canada (National Organization for the Reform of Marijuana Laws) has been sentenced to three months in jail for conspiring to traffic in marijuana.

George Arthur Falkner, who also uses the name George Baker, was sentenced after pleading guilty to trafficking in an alleged 270 pounds of marijuana between October 1975 and April 1976.

Mr Falkner organized the Canadian arm of the pro-marijuana group in early 1977, after the charge had been laid.

Judge Douglas MacKinnon noted the fact that Mr Falkner had already spent four and a half months in custody and said he also was taking into account his poor health, his age, and community service.

Mr Falkner is a 53-year-old American who was wounded and decorated in the Second World War, who later became an artist and sculptor. He moved to British Columbia under the threat of other marijuana charges in the United States.

His defence counsel said Mr Falkner took marijuana to ease a war-related lung complaint. He admitted that his client sold marijuana to friends but said he did not sell to make large profits.

The judge said testimony from character witnesses convinced him that Mr Falkner is "an exceptional person who had a lot of respect" from people who came in contact with him.

An experiment to help young drug offenders

Mexican 'prison' is miniature village – with parents

By Tim Padmore

VANCOUVER — In a unique experiment to help juvenile drug offenders, the Mexican prison system has built a detention centre that is a miniature village with homes, shops, a plaza — and parents.

It was described to the world's correction officials at an International Symposium here on The Female Offender by Antonio Sanchez Galindo, director of the Juvenile Residence for Addicted Youths at Acapulco.

Mr. Galindo said the two-year-old program has so far graduated 500 youths aged 7 to 17 back to their homes with "very good" results. There are 95 at the residence now.

"In Mexico," Mr. Galindo told **The Journal**, "drug addiction is the drug addiction of poverty. There is little heroin or cocaine, but there are problems with inhalants, especially with children, and marijuana and pills (stimulants and barbiturates)" (**The Journal**, Mar).

Family environment is often the trigger for abuse, he said: The father is alcoholic, the mother, following the tradition of machismo, is subservient, and the children turn to drugs as an escape.

"The fundamental principle is to keep the child away from that environment, to create new values."

To that end, the juveniles are placed in artificial families of 16 children parented by a surrogate mother and father.

Elementary and high school education is available. There are gardens that produce food for the facility.

Inmates work in the gardens, in industrial shops, or at a commercial plaza that includes a tortilla store and a taxi stand stocked with 20 donated beat-up taxis.

The aim, he said, is to make the facility not only successful therapeutically but also financially self-sufficient with enough income to pay for staff salaries, food, and medical services.

Because the home environment is so important, the child's family and community are "treated" too. That means everything from family counselling to teacher orientation to television programs.

The first two to four weeks at the facility are devoted to diagnosis and classification. Then comes a few months perhaps of residential treatment, graduation to a half way house, resettlement and follow up in the community extending two years from the start of treatment.

Mr Galindo said that ordinarily the child is sent to the facility with the consent and cooperation of parents but that the state has the power to insist if necessary. If the home environment permits, treatment is carried out there, he added.

Acapulco's scenic splendor attracts runaways, he said, and social workers regularly make the rounds of the beaches and mountains on the lookout for troubled youngsters.

Mr Galindo admitted, sadly, that not all of the Mexican prison system is as enlightened as he has tried to make his centre.

"Many times the laws are very good, but in reality we have many problems . . . . You can't end the cultural reality, the poverty, and the corruption with a law . . . We are taking the first steps, but it is a long road."

Drinking and drowning

By Tony Garnier

WELLINGTON, NZ — The link between drinking and driving is well known. Less well known, but statistically as significant, is the link between drinking and drowning.

In a piece of innovative research, an Auckland University pathologist, Frank Cairns, has revealed evidence that about half the adult males involved in accidental drownings over an eight-year period had too much alcohol in their blood to drive a car within the New Zealand legal limit — 80 milligrams of alcohol to 100 millilitres of blood.

Of the males over 16 who drowned and had alcohol in their blood, the lowest level was 100 milligrams of alcohol in 100 millilitres of blood. All were within the 100 to 300 mg range. About 100 people were involved in the alcohol cases drawn from the Auckland area.

The New Zealand Water Safety Council executive director, M. Frohlich, said: "It's a growing trend and we are very worried about it."

It was known that drinking was an influence in many drownings, but until Dr Cairn's findings there had been no statistics to show its extent, he said.

"Alcohol influences drowning in many ways apart from its physiological effects on the body. There are other effects just as important, such as impaired judgement, over-confidence, and delayed decision-making. Any of these can be fatal when combined with the potential dangers of water."

Although he recognized that drinking during leisure time was a firmly established way of life for many New Zealanders, Mr Frohlich urged people to "reconsider" when involved in aquatic activities. A few beers could give people a false sense of security and make them stay out a bit longer when the weather started getting rough.

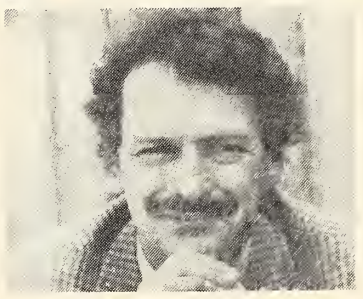
The two main areas of concern were boating and surf. Drowning victims tended to fall into two groups: teenagers or people in their early 20s who drank and over-estimated their ability or did silly things, and family men aged 30 to 40 who bought a boat and took it out once or twice a year.

"We are not talking about the experienced boaties," said Mr Frohlich. "I'm not saying that everybody is raving drunk. I'm saying that even the few beers can give you that feeling of bravado."

GILBERT

'Evidence for involvement of caffeine in human birth defects is sketchy and questionable, but it exists.'

By Richard Gilbert



Caffeine and pregnancy

Caffeine use has been declining during the past few years, largely because of huge increases in the price of coffee and tea, but it is still North America's most popular drug. There is little evidence of harm from caffeine when daily intake is below the equivalent of about eight average cups of coffee a day. Even above this level, the only clear effects seem to be chronic insomnia and persistent, unfocussed anxiety, although there has been concern about caffeine's possible role in heart disease, stomach ulceration, and bladder cancer.

Average consumption of caffeine is the equivalent of about two cups of coffee a day. Using this amount should give no one cause for concern, except in pregnant and potentially pregnant women. Because almost any level of avoidable risk to unborn children is unacceptable, and because of a body of evidence that points to the possible involvement of caffeine in birth defects and other reproductive abnormalities, use of any caffeine during pregnancy can be considered unwise.

Effect not surprising

It is not surprising that caffeine might affect the reproduction of cells and organisms. Its chemical structure is similar to that of two of the four basic building blocks of the genetic code. Some of caffeine's metabolities are even more similar. There is evidence that caffeine can upset the basic copying mechanisms involved in cell division and recombination by 'masquerading' as one of the building blocks.

Caffeine quite clearly has the ability to cause cellular changes, and to enhance the toxicity of other genetically active or mutagenic agents. It can also have antimutagenic effects. Indeed, these various effects of caffeine on cell cultures are so well known that researchers use caffeine as a tool in such areas as radiation biology, at much higher concentrations than would normally be found in human tissues.

Animal studies

In animals, administration of caffeine to males prior to mating has been found to reduce fertility and, when no reduction in fertility was evident, to shift the sex ratio of the resulting offspring in favor of females. (Perhaps paradoxically, caffeine has been found to increase the activity of sperm when added directly to semen. It is used for this purpose by commercial stockbreeders during artificial insemination.)

Giving caffeine to pregnant animals has been shown to produce a variety of reproductive abnormalities. Production of cleft palate in rat and mouse pups is the most researched effect, but there is evidence too of increased resorption, digital defects, tumors, and fetal death consequent upon caffeine administration during pregnancy.

An important consideration is the dose levels of caffeine that produce these effects in animals, and their relation to normal caffeine use by humans. The dose levels that cause birth defects in rats and mice seem high when translated into human terms on a weight-for-weight basis. Defects in some of the offspring of pregnant rats will likely be caused by a single caffeine dose of 150 milligrams per kilogram (mg/kg) or a daily dose of 30 mg/kg. These are equivalent to 120 average cups of coffee and 24 cups per day respectively for a 60-kilogram pregnant woman. Many researchers believe that weight-for-weight translations are invalid between species, and that 'metabolic weight' should be taken into account, which allows for the much higher rates of metabolic activity in small animals for each unit of body weight. Taking metabolic weight into account, the two equivalences become 35 cups of coffee for the single dose and seven cups per day for the repeated dose.

Even correcting for metabolic weight, animal studies suggest that quite high levels of caffeine use might be required before birth defects are caused. Nevertheless, seven cups of coffee a day is well within the range of reported consumption. From a 1969 study, we estimated that some 400,000 adults in Ontario were drinking this much coffee, although we don't know how many of them were pregnant. A more important point is that usually a large safety margin is applied in determining safe levels of a drug. If caffeine were being proposed as a new food additive, the manufacturer would have to demonstrate absence of reproductive abnormalities in animals at 100 times the typical human consumption.

There is also the question of the validity of extrapolating from animals to humans. Usually we have little else to go on: deliberately inducing birth defects in babies is unthinkable.

Sketchy human evidence

The evidence for involvement of caffeine in human birth defects is sketchy and questionable, but it exists. One recent study, for example, examined most of the 1800 women registering for prenatal care during a particular year at two large urban hospitals. The incidence of a number of conditions was found to vary with caffeine use, including breech presentation (which is often related to fetal abnormality), poor appearance and muscle tone of the baby, and a history of spontaneous abortion and stillbirth in the mother. This analysis corrected for cigarette use, which is highly correlated with caffeine use. Many other studies did not, which is one reason why they are questionable.

As well as affecting fetal development by its genetic effect, caffeine can also cross the placenta and affect the unborn baby as a stimulant drug. Breathing problems in newborn infants can be corrected by caffeine administration, which has led to speculation that the problems might be the result of withdrawal from caffeine that the baby had been regularly experiencing via the placenta. Caffeine also passes into breast milk, so it appears that mothers who drink coffee during pregnancy might do well not to quit suddenly at delivery. Moreover, caffeine may stimulate production of milk, providing a further possible reason for continuing moderate use of the drug.

Giving up coffee or tea during pregnancy, or, even better, when pregnancy is planned, seems like a good idea. Many women do, but more often later on in pregnancy, when the risk of genetic damage declines. (The decline in caffeine use may be because caffeine is metabolized very much more slowly in late pregnancy, thereby prolonging the effect of each cup of coffee.) Although it cannot be argued that the risk from continuating to drink two or three cups of coffee a day during pregnancy is more than slight, the nature of the risk points to abstinence and certainly demands that no greater amount be consumed.

As nuclear reactors proliferate, and the risk of radiation grows, there may be further cause for concern. More than one study has shown that caffeine enhances the ability of other agents to cause genetic damage.

Next month: Should we try to prevent drug abuse?

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

'We must agree on our meanings'

A plea for more scientific usage

Please permit me space for one more kick at the "dependence" cat and to reply to the efforts of Lise Anglin, documentalist, and Dr Oriana Kalant (**The Journal**, March).

At the outset let me advise Lise Anglin that someone with the title "documentalist" is not in a position to criticize anyone for using modernistic jargon. Besides, the point of my letter was to reduce the use of jargon, not promote it. Dr Kalant feels that

Dependence revisited....

she would be at a great loss if she could not use the terms dependence and addiction and says I should suggest a replacement.

I have no argument with the word "dependence" — it is a good English word, but like all words it is only useful if everyone who uses it agrees on a particular meaning. A cowboy may be dependent upon his pistol and a professor on his paycheque; we know what that means, but what does it mean to say that a person is dependent upon a drug? A textbook on the subject (Thompson and Schuster, *Behavioral Pharmacology*, Prentice-Hall, 1968) defined dependence as "the repeated and reliable self-administration of a drug" and I would have no objection to the word if everyone defined it in this way.

Unfortunately, as the term is currently used it describes not only the behavior of self-administration, but also suggests a state of affairs in which the individual *needs* the drug to maintain the integrity of his body (physical dependence) or his mind (psychological dependence). In the original exchange of letters between Kalant and Anglin (Nov 1, 1978), it is apparent that the latter definition is what they mean. By using the word this way they are attempting to describe the behavior and explain the mechanism responsible for it all at once. The factual evidence presented by Dr Kalant herself shows that this explanation is probably wrong.

If we can restrict ourselves to using the word "dependence" as Thompson and Schuster define it, I will be happy, but if we persist in using it as an explanation for the drug taking process, an incorrect one at that, we had better drop the word from our vocabulary. This should not distress Dr Kalant, who cannot think of a better word; after all, she admits that drug taking is governed by the same behavioral principles as eating and gambling and we can talk about these behaviors without resorting to "dependence" and "addiction."

I know how difficult it is to break lifetime habits like this. I have taught a course on behavioral pharmacology for six years now and have not made it through a semester yet without using the dreaded words. However, I am always careful to define these words in behavioral terms before I use them. I suppose I can ask no more of anyone else.

Neither the cause of communication, the beauty of the English language, nor the love of the ARF should be threatened by what I suggest. After all, accuracy and precision are the hallmarks of any scientific endeavor and I assume the research going on at the ARF is scientific. Is it asking too much for its language to be the same?

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Client is the key to treatment choice

It was encouraging to see a news item on self-help groups (**The Journal**, April). There is much talk about such groups nowadays. It is really helpful to hear from people such as Ms Millicent Buxton who has had dealings with the professionals as well as self-help groups. The experiences of such people could help to bring down the barriers between professionals and self-help groups.

Based on her personal experiences, Ms Buxton has generalized that "it's good to go it alone." I have difficulty in agreeing with her views on this score. In my opinion, it is not the treatment modality but the client who is of utmost importance in the outcome of intervention. The choice of where to go for help, that is the selection of a particular help source and consequent benefits from it, is contingent upon one's psychological orientation and not the treatment modality as such.

How a self-help group could be used and when it could be used depends on the individual needs. I could visualize a self-help group being used in a variety of ways. It could be used before, after, or concurrently with treatment. Moreover, these groups could be used alone as self-sufficient entities and seem to work for many people.

Peers play an important part in the self-help groups. They can provide support and are also capable of influencing negatively. Again, we should not generalize, because not all members of the self-help groups will have the same outlook on life. I have personally known people who are members of Alcoholics Anonymous and work as alcoholism counsellors and do a good job.

There are some self-help groups which are enlightened and progressive in the sense that they do not make members dependent on them. In this context, I am thinking about groups which raise consciousness, such as Women for Sobriety.

Narendra Sharma,
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'It's not so good to go it alone'

Regarding the article: "It's good to go it alone," says AA, NA grad (**The Journal**, April). All the experience of Alcoholics Anonymous leads me to write to express my sympathy for poor Millicent Buxton. There are no classes thus no graduates in AA. It provides a program for living without alcohol and Ms Buxton is dry, not sober yet.

It is unfortunate that **The Journal** publishes articles like this because it is clear that both Ms Buxton and her unfortunate clients will drink (and use) again without AA meetings.

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The Journal Special Report

UPDATE: The Brewers/ARF File

In April, **The Journal** published the full text of a critique prepared by the Brewers of Ontario of an Addiction Research Foundation of Ontario document entitled, A Strategy for the Prevention of Alcohol Problems. The Brewers' critique was entitled, Ontario Deserves Something Better from the Addiction Research Foundation. It was published together with a Response by the Foundation. This month, further comments from the Brewers — Observations on Addiction Research Foundation Response to Brewers' Critique — and a Rejoinder by the Foundation. The documents are printed in full as a contribution to understanding the debate.

Brewers

OBSERVATIONS BY THE BREWERS on the Addiction Research Foundation's Response to the Brewers' Critique

1: The style of the critique . . . indicates that the main purpose is to discredit the work of the Foundation, at least that which relates to the issue of primary prevention.(*)

There are no statements in the Brewers' Critique which could be construed as discrediting the work which *relates to the issue of primary prevention.*

The purpose of the document as stated was *to bring to the attention of the government of Ontario both the inadequacy of the Addiction Research Foundation Paper as an accurate and supposedly objective statement of alcoholic beverage trends in the province and particularly the misrepresentation it presents as to future problems which might arise.*

The brewers recognize that there is a problem with alcohol consumption. However, this particular Strategy Document did not present to policy-makers an objective and accurate picture. This should be corrected.

2: Since sales data are reported for the fiscal year, to estimate sales during the calendar year 1975, for example, requires that the data for the year ending March 31, 1976 be available.(*)

As pointed out in our critique, data for an additional two years (ie, for fiscal years ended March 31, 1976 and March 31, 1977) were available well before February 1978, the date of issue of the Strategy Document.

3: We have found that there are sometimes discrepancies between federal and provincial reports, and revisions of the figures in later years.(*)

It is true that Statistics Canada does revise its figures in "The Control and Sale of Alcoholic Beverages in Canada" occasionally, because of an error that has been made. The Liquor Control Board of Ontario is the source for the Statistics Canada figures and its reports are available to the Addiction Research Foundation. For at least the past 10 years no revisions have been made in the volume of sale or value of sale figures in the Liquor Control Board of Ontario reports.

4: Since our research involves both time trend studies and inter-provincial comparisons, we have found it to be best to use consistently a single standard source — in this case the reports on Control and Sale of Alcoholic Beverages prepared by Statistics Canada.(*)

Perhaps it may be necessary for inter-provincial comparisons to use "Control and Sale of Alcoholic Beverages" as the source document, but why would the reports of Ontario's own Liquor Control Board, which are much more current than the above-mentioned document, not be used by another Ontario agency for a paper which concerns only Ontario? In addition, examination of the Statistics Canada volume and value figures would have revealed that they are the same as those published in the Liquor Control Board of Ontario reports, except in those cases where there is an error in the Statistics Canada publications, which are later corrected.

Further, certain Addiction Research Foundation scientists do use the Liquor Control Board of Ontario as a source. (See "Alcohol Economics & The Public Purse", by Richard Gilbert, *Addictions*, Summer, 1976.)

5: The forecast was done for us by our consultant on economics, Dr H. - H. Lau, and completed in February 1977. At the time, the latest report on Control and Sale of Alcoholic Beverages was for the year ending March 31, 1975.(*)

Had Dr Lau updated the model for the Strategy Document, he would have had data for one more year as the March 31, 1976 report on "Control and Sale of Alcoholic Beverages", became available in October, 1977. Further, had he used the Liquor Control Board of Ontario reports, he would have had two more years' data.

6: It should be pointed out that it is not necessary to include all available data points in the estimation of the model for use in forecasting. As long as the structure of the equation is judged to be reasonable on economic grounds, the model need not be re-estimated each time an additional observation becomes available.(*)

In a rapidly changing environment, it is always better to use additional and up-to-date information. Certainly, when the outdated graph was being presented to Ontario legislators, the deviation from actual for the next two years should at least have been pointed out.

Organizations such as the Conference Board of Canada and Data Resources of Canada are continuously revising their forecasts in an attempt to reflect current conditions, as is the Government of Canada.

7: For instance, the Red Book version of the Bank of Canada RDX2 econometric model of the Canadian economy which was released in 1977 includes data points up to 1972 only. Today, it is still widely used by government agencies including the Department of Finance and the Bank of Canada in making policy simulations.(*)

This model is not a forecasting model, but a structural one, designed to evaluate *policy simulations.* It is extremely intricate and complex, and was never intended for periodic updating, as any good forecasting model should be.

8: In fact, one can point out a potential danger of incorporating all available data points in estimation because data for the most current observation may be revised subsequently. A clear example concerns the value of beer sales for the province of Ontario recorded for the financial year ending on March 1976. The figure was reported in October 1977 to be $560,655 thousand. In September 1978, this sales value was revised downwards to be a mere $463,725 thousand even though there were no revisions in the corresponding volume figure. . . . In the case of the equation for beer, it is clearly better not to include preliminary data for financial year 1976.(*)

The figure cited for value of Beer Sales in the October 1977 issue of Control and Sale was never "revised", it was "corrected". If the source, Liquor Control Board of Ontario, had been referred to, the correct figure could have been acquired. It could be expected that the $560,655 thousand anomaly in the trend of this series would have generated further investigation, particularly to a user experienced in time series and trend analysis!

9: . . . we are justified in using the model which was estimated based on final data not subject to revision . . . . Given the good performance of the model in the historical

* Refers to excerpts from the "Response by the Addiction Research Foundation to the Critique by the Brewers of Ontario."

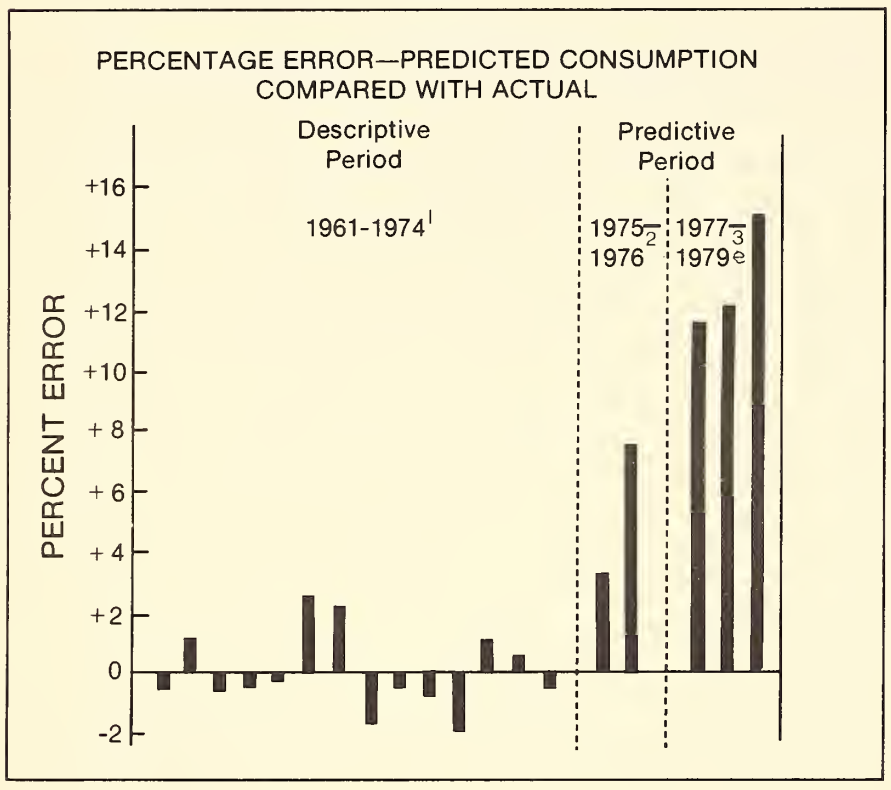
period, we should have confidence in the medium-term predictions even though the short-term predictions may be off-track when compared with preliminary data which have just become available. . . . It is quite likely that following the levelling off of consumption in 1975 and 1976, there will be a rebound similar to the experience in the late 1960s.(*)

The model did not use *final data not subject to revision* in any case, as both population (three years) and Personal Disposable Income (four years) statistics were subsequently revised. These revisions were available prior to February of 1978. Real Personal Disposable Income for the last four years in the model was actually higher than what was in the model (based on revised figures); thus its effect could have been exaggerated in the equations.

The *good performance of the model in the historical period* would be expected, considering that the historical data points are the very components of the model!

In the predicted years, the model has not performed well. (See Figure 1.)

Figure 1



(1) 1961 - 1974: The forecasting equation was based on data for this period and the predicted values varied by relatively small percentages from actual, as would be expected.

(2) 1975 - 1976: This is the first period in which the model was used in a predictive mode. The percentage by which the predicted values of consumption varied from actual are comparatively large, both in the same direction and growing, a much different situation than existed in the late 1960s from which there was a rebound.

(3) 1977 - 1979(e): This is the period when Addiction Research Foundation researchers say that it is likely there will be a rebound. It is to be noted that, to the contrary, the error is increasing and is now very large, which would confirm the poor performance of the model as a predictive tool.

Forecasts based on equations which include two years more data and the revised data mentioned previously, give a substantially lower forecast, even using the same forecast relationships as in the original model. This was demonstrated in the Brewers' Critique.

We agree that not all data points will fit exactly on a trend line, and that fluctuations from year to year should certainly be expected. However, data now "in" for 1977, as well as 1975 and 1976, and almost complete data for 1978, indicate that for the fourth year in a row, consumption has "levelled off". There has been no indication of a *rebound similar to the experience in the late 1960s.* (See Figure 1 above.) By ignoring more current data the discontinuity so evident in many aspects of our economy and society since 1973 or 1974, was not picked up in the Addiction Research Foundation model.

It is interesting to note that one of the Addiction Research Foundation's own researchers, Dr Richard Gilbert, has recognized current trends and has predicted a decline in alcohol consumption in Ontario in 1979. In **The Journal** of January 1, 1979, he commented: *. . . trends in alcohol consumption in Ontario are similar to those in most of the rest of North America, and so I shall stick my neck out and say that alcohol consumption generally may very well decline in 1979 . . . Thus the net result will be that per capita alcohol consumption in Ontario will decline in 1979.*

10: However, what is important in determining alcohol consumption is the real price (nominal price divided by the C.P.I.) of alcoholic beverages and real income as well. If the historical trend rates have underestimated alcohol prices, they have also underestimated the C.P.I. These underestimations tend to offset each other . . . As a matter of fact, our predictions of the changes in the real prices of beer and spirits for calendar year 1975 were extremely good. (We prefer not to use 1976 data because they are subject to revisions.) For example, we predicted a 2.3 per cent decline in the price of beer relative to the C.P.I. compared with the actual decline of 2.0 per cent. For spirits, the prediction was a decline in real price of 3.1 per cent versus an actual decline of 2.8 per cent.(*)

Of course the "real" price of any item is a function of the nominal price and the C.P.I., and if both are wrong to the same extent, the "Real" price will not be changed. However, if the degree of error is not in the same proportion in both variables, the errors will not "OFFSET" each other.

Again the use of historical relationships between 1961 and 1974 for forecasting the decade ahead to 1985 assumes a degree of continuity which is simply not warranted by the facts.

The values of the four exogenous variables were sufficiently different to significantly affect the forecast. As shown below, there is a significant difference between the correct value of the four variables and the values used in the Addiction Research Foundation model.

TABLE I
Rate of Increase or Decrease Calendar Year 1975/1974 and 1976/1975

	1975/1974		1976/1975	
	Based on A.R.F. Model Prediction	Based on Correct Figures Using Actual Data	Based on A.R.F. Model Prediction	Based on Correct Figures Using Actual Data
Real Personal Disposable Income Per Capita	+ 5.3%	+ 3.0%	+ 3.4%	+ 4.1%
Real Price of Spirits	— 3.1	— 2.5	— 2.3	— 1.5
Real Price of Wine	+ 3.6	— 2.1	+ 2.4	— 2.4
Real Price of Beer	— 2.3	— 1.7	— 1.8	+ 2.3

In addition, there are arithmetic errors in the two selected figures (those with the least difference) cited by the Addiction Research Foundation in the above quote. These errors falsely enhance the claimed precision of the predictions for 1975 compared with 1974 (— 2.8% for spirits price should be — 2.5p; — 2.0% for beer price should be — 1.7%).

Had the model included at least the data which were known for the two additional years 1975 and 1976, plus the revised values of Real Personal Disposable Income Per Capita for 1971 - 1974, the forecast would have been quite different as previously mentioned under point 9.

Again, it was very improbable that 1976 data would be revised if the best source of data had been used.

11: In the field of alcohol studies, it has become standard practice to express alcohol sales or apparent consumption rates in terms of the "drinking age" population, ie persons 15 years of age and older. The validity of this practice is well established by a large body of survey and other data respecting the distribution of alcohol use in general populations . . . We acknowledge that the designation in the graph . . . might have been more explicit on this point. . . . However, in the present instance, it was felt to be desirable in the interests of effective communication to simplify labels and keep footnotes and documentation to a minimum.(*)

We do not question the validity of the use of adult population as one basis for describing consumption. However, in a document intended *primarily for legislators who do not have time to read lengthy submissions* (*) and who would not necessarily be familiar with *standard practice* (*) in the field of alcohol studies, in the *interest of effective communication* (*) the correct label should have been used instead of the wrong label.

12: The primary purpose of the graph, after all, was to indicate the trend, not the level of consumption.(*)

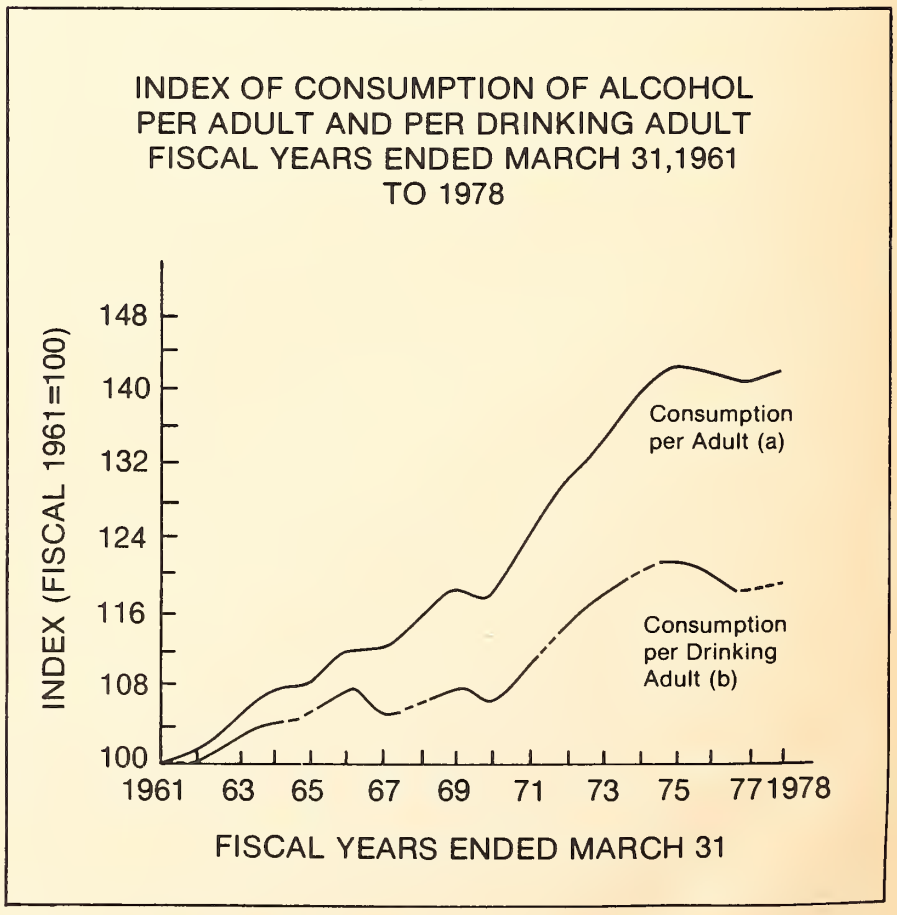
Although the primary purpose of the graph was to indicate the trend, not the level of consumption, the Addiction Research Foundation has always placed great emphasis on level of consumption as an indicator of alcohol problems. To those subscribing to this theory, the level of consumption being incorrectly labelled would indicate a much more serious situation than that which actually exists.

In addition a trend indicated by "per capita" consumption would not necessarily be the same as "per adult" due to the change in the age distribution of the population.

13: Finally, while it is obvious that a per capita sales rate based on the population of drinking age (15 and older) will be greater than one based on the total population, this is not to say that the former overstates the average consumption of those who use alcoholic beverages. In fact, the rate based on drinking age understates average consumption since only about 80% of persons 15 and older use alcoholic beverages.(*)

Had drinking population been used, the trend shown on the graph would have been much less exaggerated, as the percentage of the population who drink has been rising over the years, perhaps from 73% to 85%, from 1961 to the present (not 80%)(1).

Figure 2



(a) Adult population based on persons 15 years and over as published by Statistics Canada.

(b) Drinking adult population based on Brewers Association of Canada estimates calculated from irregular figures appearing in Addiction Research Foundation publications over the period under review.

14: Indeed, even by 1975 an international group of researchers meeting under the auspices of the World Health Organization concluded that: "The relationship between heavy consumption and excess mortality is manifested in the general population in a covariation of liver cirrhosis mortality and per capita alcohol consumption".(*)

The Addiction Research Foundation response fails to report that Messrs. Popham and Schmidt were part of this small group of international researchers and that the publication referenced as Bruun, et al., "Alcohol Control Policies in Public Health Perspective", the Finnish Foundation for Alcohol Studies, Helsinki, Volume 25, 1975, p. 90, was, in fact, a collaborative project of the Finnish Foundation for Alcohol Studies, the World Health Organization Regional Office for Europe, and the Addiction Research Foundation of Ontario and that Messrs. Popham and Schmidt are listed as authors.

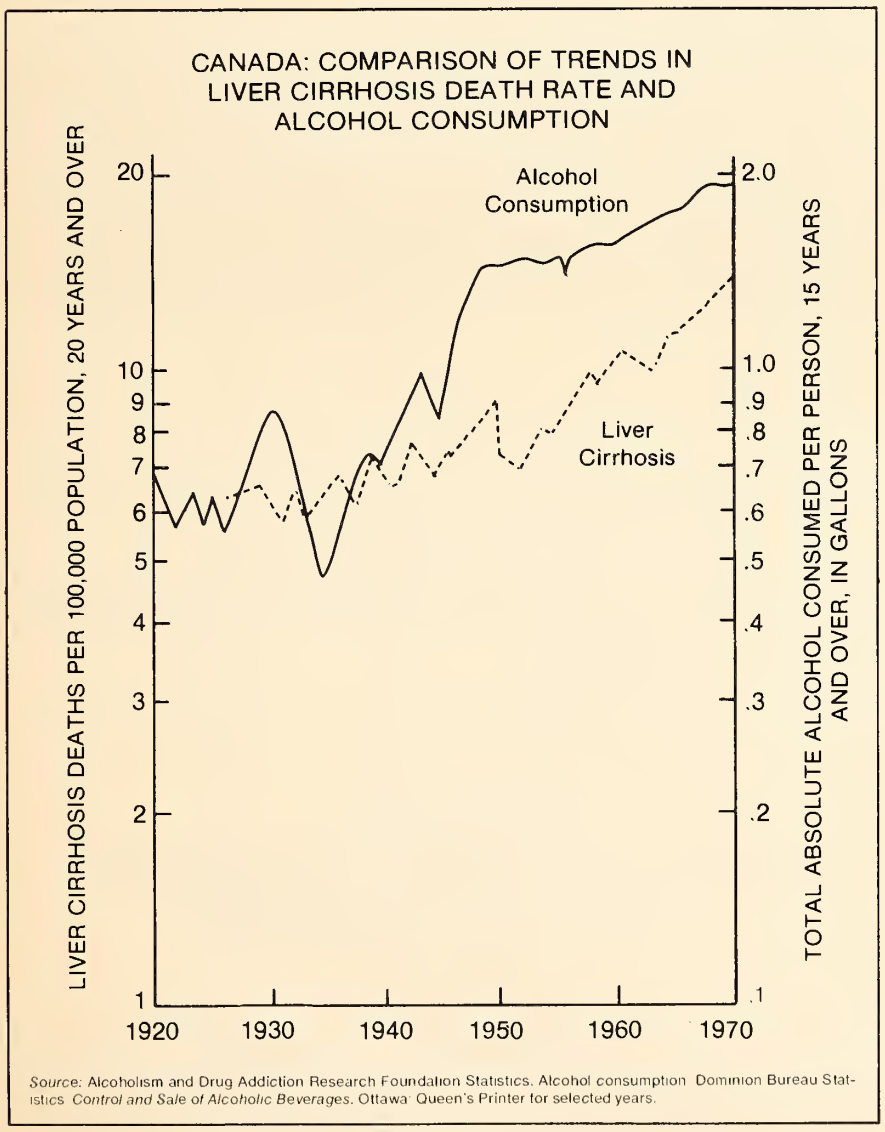
Further, the above quotation attempts to summarize or paraphrase the conclusions appearing on page 44 of Chapter 3 of the book, which read as follow:
The covariation of per capita consumption and indices of health damage is not always easy to detect. The available measures are often subject to sources of considerable variation which can obscure any effect of changes in consumption level. Nevertheless, the alcohol consumption level is, in most cases, a high accurate predictor of the cirrhosis death rate. There is also suggestive evidence, so far observed in several temporal series, of covariation of consumption and general mortality when the latter is taken as the excess of male over female mortality in the middle age range. In this regard, a characteristic of mortality in the Western world during the past generation has been the lack of improvement in middle-aged men as compared to other segments of the population. It is by no means inconceivable that the increase in alcohol consumption over the same period has been a contributing factor.

Thus, it can be seen that this group of researchers are not as certain about their findings as would be suggested by the quotation which attempts to summarize or paraphrase the concluding section of Chapter 3.

Further, in arriving at even these very tentative conclusions, the researchers have placed considerable emphasis (p. 43) on liver cirrhosis mortality rates for Paris, 1907-56, and are attributing the reduction in liver cirrhosis deaths per 100,000 population to a severe reduction in the supply of alcoholic beverages during war years although no consumption data is shown in this regard.

The researchers have conveniently ignored at least one major Canadian example which suggests such a direct relationship does not exist. As indicated in Figure 3(2), during the period 1926-1936, consumption of alcohol in Canada first increased by 69% and then fell by 47% while at the same time the rate of liver cirrhosis deaths showed very little variation.

Figure 3



Source: Alcoholism and Drug Addiction Research Foundation Statistics. Alcohol consumption: Dominion Bureau Statistics. *Control and Sale of Alcoholic Beverages*. Ottawa: Queen's Printer for selected years.

15: As in the case of sales data, the Brewers' Critique faults us for giving a misleading impression of trends through the use of outdated cirrhosis mortality data. . . . The Brewers' Critique attributes considerable importance to the apparent plateau in cirrhosis mortality 1974-1976. . . . Given that the cirrhosis death rate is an indicator of the prevalence of such problems (as noted in the previous section), a plateau in the rate would be expected to accompany the plateau in alcohol sales.(*)

The levelling off in cirrhosis deaths may be a temporary aberration, or it may not, but with the levelling off in alcohol consumption in 1975 and 1976 and believing that cirrhosis rates and consumption of alcohol are closely related, the Addiction Research Foundation, if it wished to present an objective view, should have indicated that there would be a levelling off in alcohol problems due to the levelling off in consumption.

16: The Brewers' Critique argues that the correct rate of change in cirrhosis death rates over the period 1950 to 1973 is 4.79% rather than the 8.80% reported by us in the Strategy Document. Our figure is the average increase in the death rate expressed as a percentage of the base year (1950). . . . Both methods of calculation are legitimate. The one is often used by epidemiologists, the other by economists and demographers.(*)

This is a small point, but again illustrates the Addiction Research Foundation's predisposition toward a presentation giving an exaggerated view. The general understanding of rate of increase is the Brewers Association of Canada interpretation. This would be much better understood by legislators who are not epidemiologists. As a matter of fact even on the Addiction Research Foundation method, the figure is incorrect on the basis of data shown; it should be 8.41% rather than 8.80%.

17: The Brewers' Critique quotes Schmidt, one of the authors of the Strategy Document, as saying that "he and his co-workers could be justly accused of some overstatement and oversimplification". This statement is quoted out of context. Schmidt was addressing a group of scientific colleagues and meant that we sometimes did not put in all the traditional qualifiers. He did not mean that we lacked confidence in our main conclusions.(*)

The statement quoted by the brewers was: *Dr Schmidt conceded that in some of their work, he and his co-workers could be justly accused of some overstatement and over simplification. "To a degree this was due to a deliberate strategy to secure a hearing for a point of view which ran counter to the prevailing sentiment. In retrospect, we now doubt the effectiveness of such a strategy, and are inclined to take a more conservative approach."* (Brewers' Critique).

This was a quote made by Dr Schmidt in the course of an interview by John Shaughnessy appearing in **The Journal** published by the Addiction Research Foundation, July 1, 1977. We included the entire interview article in our Critique.

There was no suggestion in the Brewers' Critique that the Addiction Research Foundation lacked confidence in its main conclusions.

18: Finally, the Brewers' Critique states that our conclusion that the real price of beer has declined is invalid because we failed to take into account increases in the Ontario sales tax and in licensee mark-ups. . . . We disagree with the contention of the Brewers' Critique that increases in the cost of alcoholic beverages to customers of licensed drinking places should have been included. In the first place, only about 25% of all sales of Canadian beer is to licensees. . . . (*)

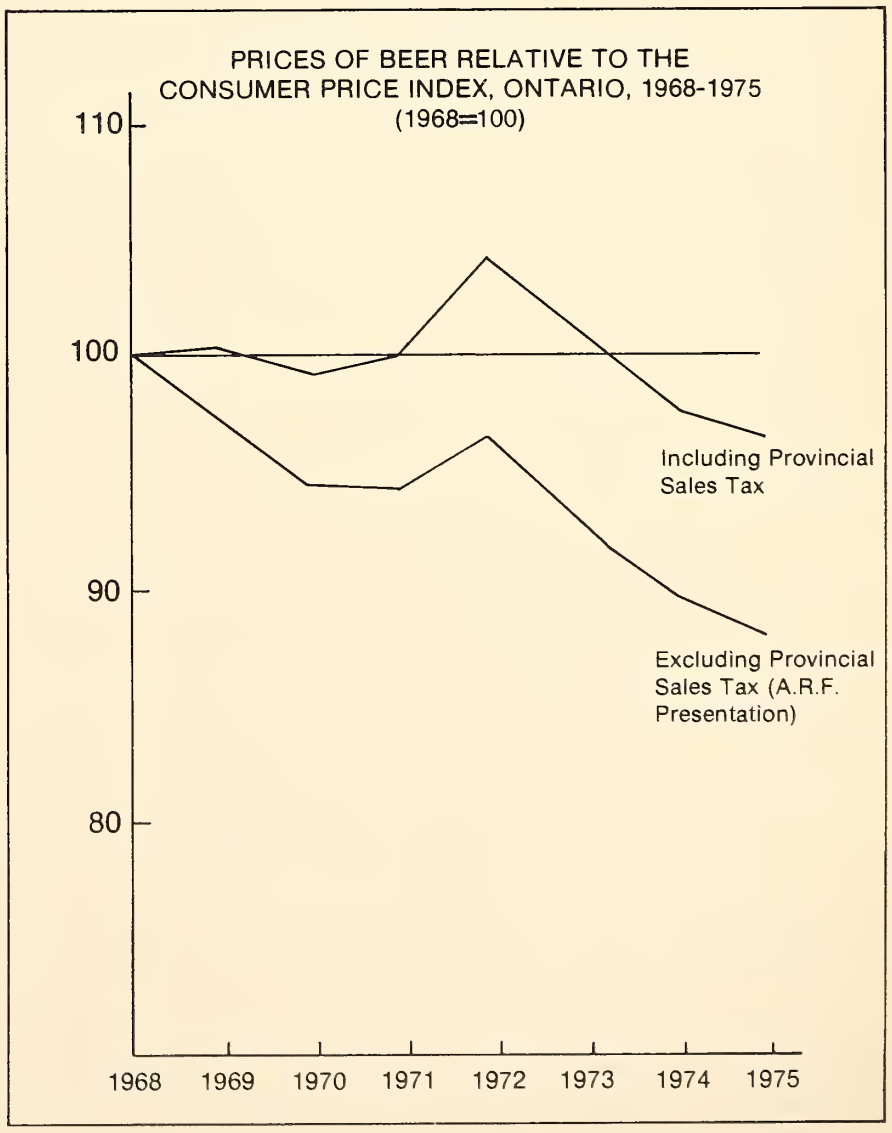
We agree that licensee mark-up could fall into the category of service, etc. and thus there may be some justification for it to be excluded from the price. However, 27% of the beer is consumed on licensed premises and cannot be ignored. When the licensee mark-up is eliminated, and the additional 5% provincial tax on packaged beer from 1969 forward and 10% provincial tax on draught beer from 1972 forward are included, the price of beer in 1975 is only minimally lower than in 1968 (3.7% below 1968, as compared with the 11% shown on the Addiction Research Foundation graph in the Strategy Document.)

19: However, this does not affect the direction of the trend but shifts the price level upwards by 5% from 1969 on.(*)

By inclusion of the provincial sales tax, the price level for packaged beer is shifted upward by 5%, but for draught beer it is shifted up by 10%.

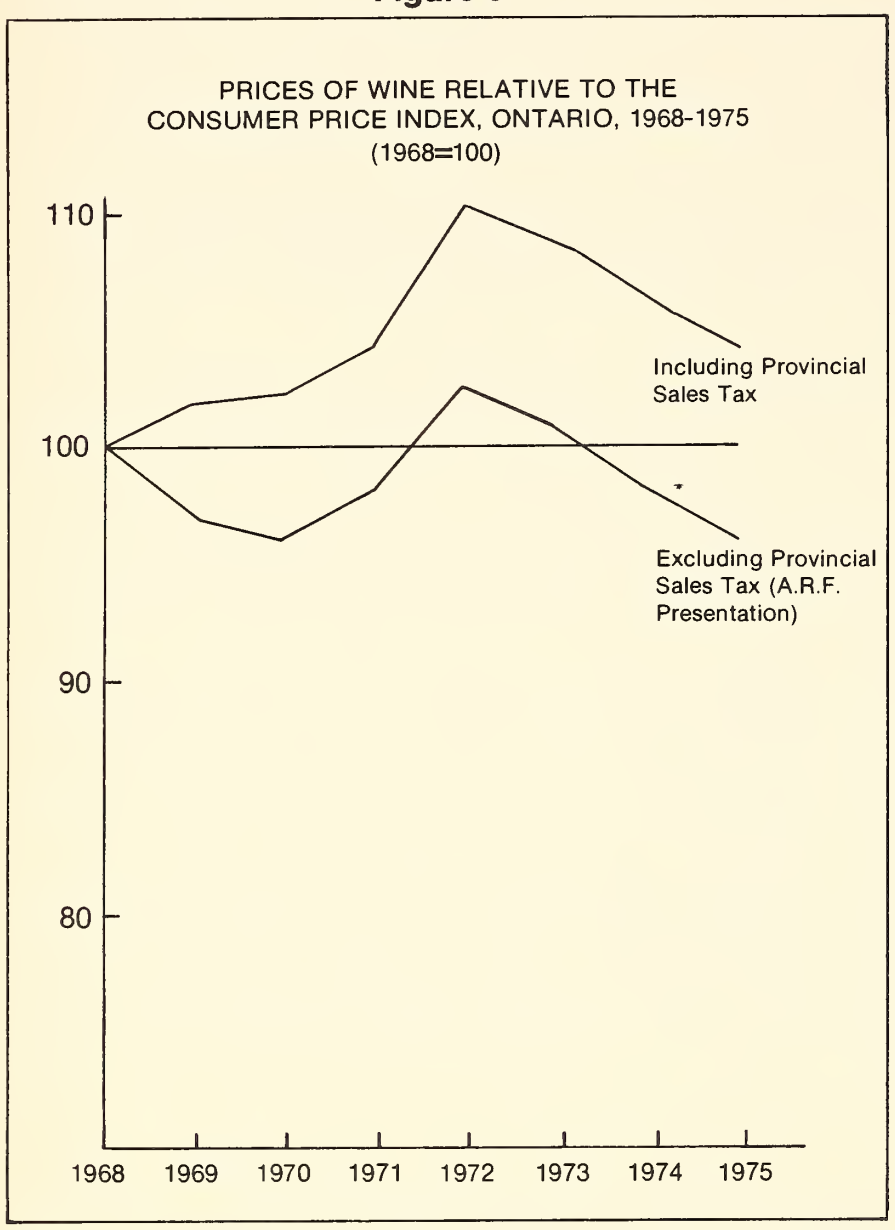
The graph following (figure 4) shows the effect of this on the beer price and compares it with the original Addiction Research Foundation graph. It should be noted that for the period under review in the graph (1968-1975), the price of beer was equal to or higher than prices generally for four of the seven years. The direction of the trend in the three latter years is down slightly, but not nearly in the magnitude indicated in the Strategy Document.

Figure 4



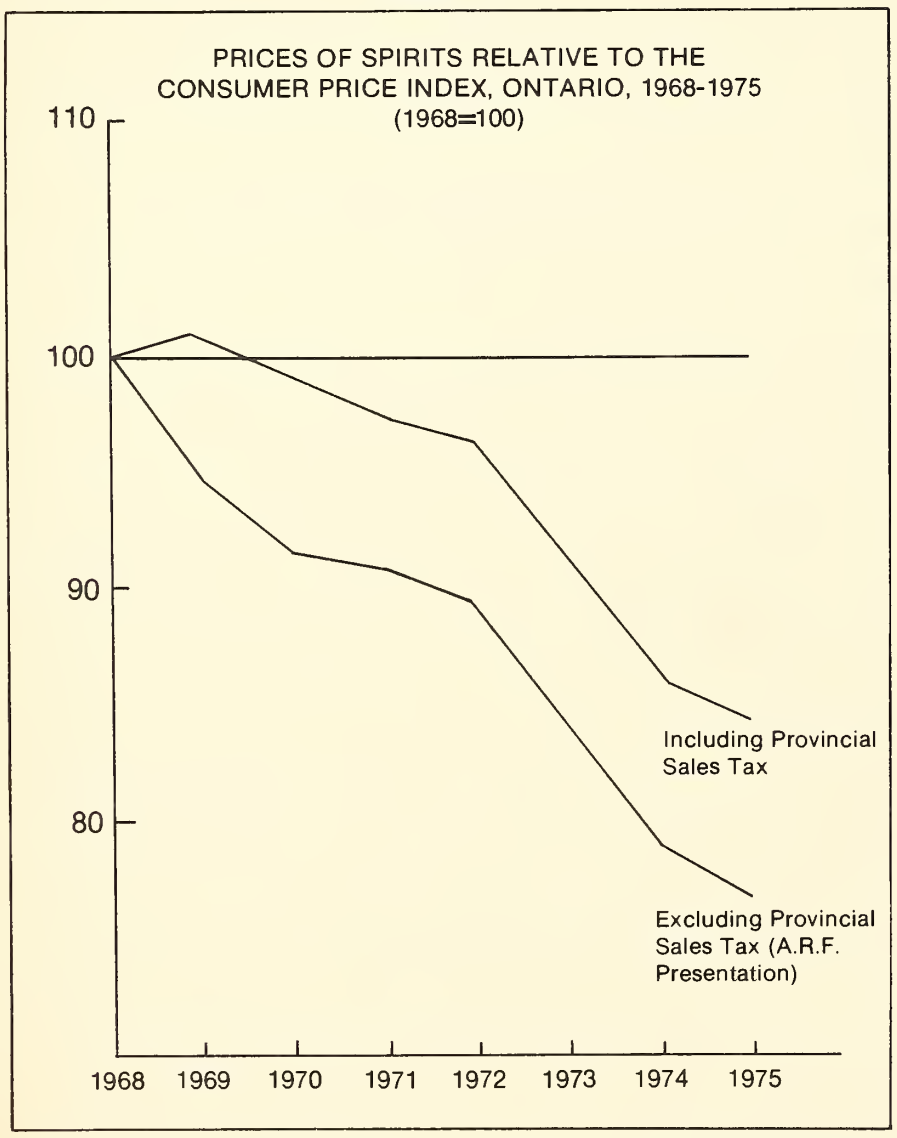
The effect of the provincial sales tax on the wine price index reveals that wine has been more expensive compared to the consumer price index throughout the whole period under review. Figure 5 compares the price including the tax with the Addiction Research Foundation presentation excluding the tax.

Figure 5



The effect of the provincial sales tax on spirits prices is illustrated in Figure 6. Here the trend is still down, but again, not to the extent shown by the Addiction Research Foundation presentation.

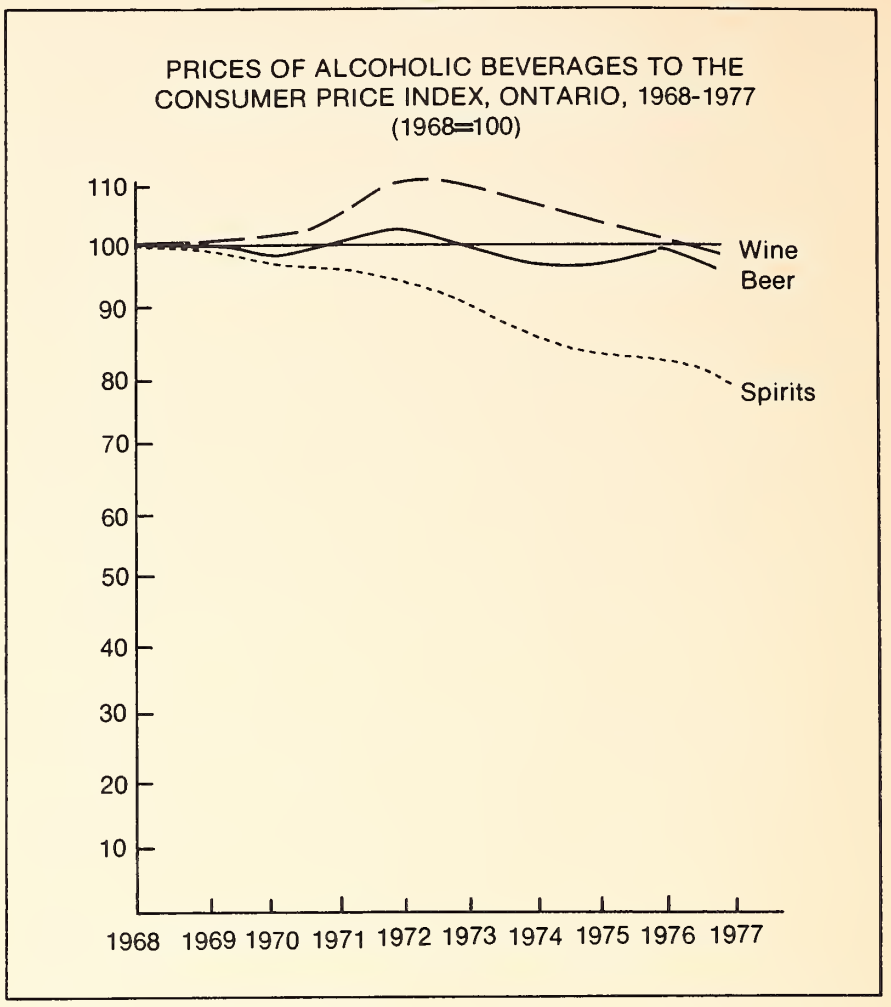
Figure 6



In this connection, an additional figure is included to put the above-mentioned trends in better perspective. By using a graph with only a portion of a scale being shown (or at least without a break in the scale) gives a visual distortion.

In the case of beer and wine, in general, prices have kept up with consumer prices. Although this is not so for the price of spirits, there has not been the precipitous drop which is envisaged by looking at Figure 6.

Figure 7



20: Observations on section of Response dealing with *Apparent inconsistency of our Recommendations.(*)*

Regarding the assessment of legal control measures, we can find nothing in the Addiction Research Foundation response which alters our concerns regarding the lack of substantiation for its recommendations. Neither the references in the response to supporting evidence such as *Indexes of acceptance* . . . (*) and . . . *a survey of public attitudes in Ontario* . . . (*) which, incidentally, were not included in the Strategy Document nor the explanation that detail was left out of the Strategy Document because it was . . . *intended primarily for legislators who do not have time to read lengthy submissions*, are, in our opinion, adequate.

The anecdotal "evidence" of a letter to a University President on the pros and cons of opening a pub on his campus is hardly a more detailed analysis of the complex issues which would lead to recommendations for a moratorium on the liberalization of alcohol control measures.

Footnotes

*Refers to excerpts from the "Response by the Addiction Research Foundation to the Critique by the Brewers of Ontario."

(1) Smart, Reginald, G., "The New Drinkers", page 3.
(2) "Beer, Wine and Spirits: Beverage Differences and Public Policy in Canada", Report of the Alcoholic Beverage Study Committee", May 1973.

The ARF

REJOINDER BY THE ADDICTION RESEARCH FOUNDATION to Observations by the Brewers

The Brewers' "Observations" on our response to their critique consist mainly of a restatement of their original points, which we have already answered (**The Journal**, April 1, 1979). We see no reason to alter our earlier response. There is nothing in the Brewers' argument which weakens the main principles involved, and these are the important considerations in relation to policy. The larger the amount of alcohol consumed by a population as a whole, the larger will be the number of heavy consumers and the greater will be the damage to public health. There is no better indicator of the trend in the prevalence of alcohol related problems than changes in the rate of death from cirrhosis of the liver. The death rate from cirrhosis in Ontario has been rising rapidly since World War II and has shown the highest rate of increase of any cause of death. A drop in real price of alcohol generally leads to an increase in consumption and the price of alcohol has characteristically declined relative to other consumer goods since World War II. The increase in overall consumption has been associated with gradual relaxation of restrictions on availability of alcohol, a lowering of the drinking age, and the rise of extensive life-style advertising of alcoholic beverages. It has been accompanied by a major and costly increase in public health problems associated with heavy drinking. A moratorium on further liberalization and maintenance of a reasonably constant real price of alcohol is in the interest of public health. These are the important findings and conclusions and they are in no way negated by the Brewers' criticisms.

From the standpoint of research, the question of importance with respect to the forecast is not what effect the addition of one or two years might have on the predicted 1985 consumption, but why the forecast predicted a higher consumption than has apparently occurred during the last four years. A fully satisfactory explanation is not likely to be possible until data are available to permit an appropriate time trend analysis. However, it now seems clear that the use of currently available values for disposable income, and the other economic indicators in the model will explain only a part of the discrepancy between the predicted and actual alcohol consumption levels. Additional factors, which have not previously emerged as significant determinants of alcohol consumption, apparently have become operative during the past four or five years. Certainly, less has been spent on alcoholic beverages than the degree of economic accessibility would lead one to expect. It may prove useful to begin the search for an explanation by an examination of indicators of 'consumer pessimism,' such as increases in saving at the expense of non-essential spending.

In regard to the validity of cirrhosis mortality as an indicator of alcohol problems in general, we must first object to the extraordinary implication of the Brewers' "Observations" that the Bruun et al. work is untrustworthy because two ARF researchers were among the 11 authors. Secondly, we submit that the conclusion we quoted from this work and the longer quotation cited by the Brewers, above, are consistent with one another, and display about as high a degree of certainty on this issue as 11 scientists from six countries and five different research organizations are ever likely to express. Thirdly, we have published data demonstrating that the relationship generally holds in Canada.† One example of the evidence, cited in the Strategy Document, is that of cirrhosis mortality and alcohol consumption in Ontario. Evidently this example bears repeating and the relevant graph is, accordingly, provided below. (Graph 1)

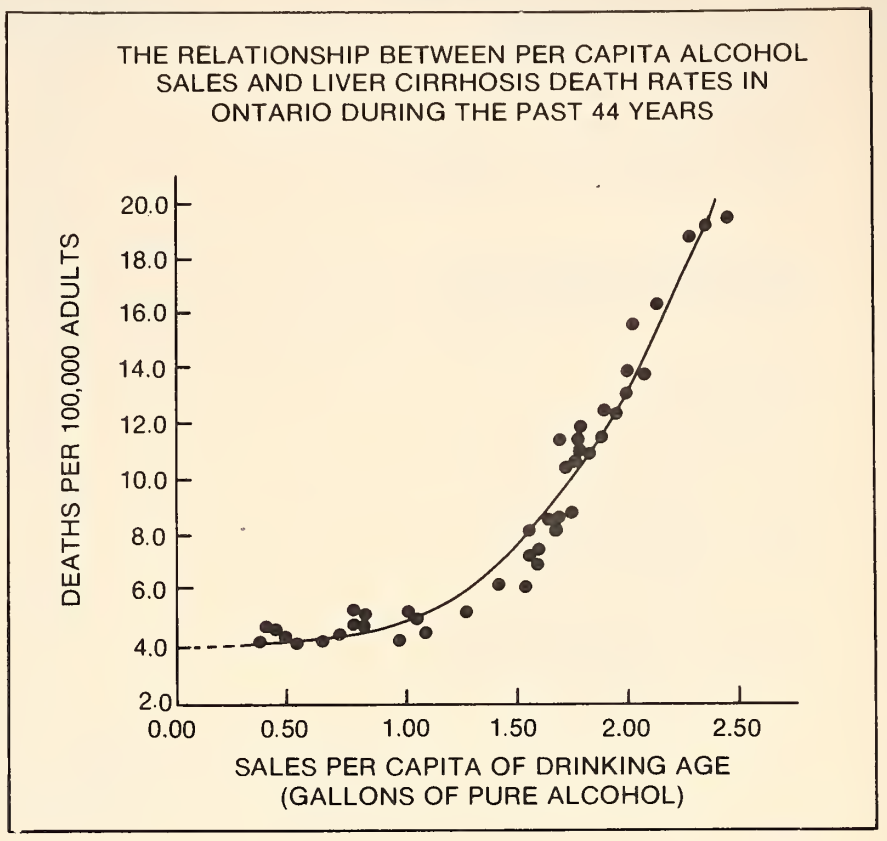
The Brewers have missed the point that when per capita consumption is as low as it was in the period 1926 - 1936 (about one-third of the present level or less) a very large proportion of all deaths from cirrhosis is due to causes unrelated to alcohol use. This unrelated rate is known to show little more than the chance fluctuation evident in this part of the Brewers' Figure 3. However, as consumption rises alcohol accounts for a growing proportion of cirrhosis deaths, and the correlation grows progressively better, as shown in our Graph 1. Therefore the lack of corresponding change between consumption and cirrhosis deaths in the period cited by the Brewers is irrelevant to the present discussion.

Finally, we have maintained that the cirrhosis mortality rate is a very good indicator. We have not said that it was perfect — which would be inconceivable — and indeed, exceptions have been noted and discussed by ARF scientists in several publications.†† However, these exceptions should not obscure the fact that, in general, the rate has proved to be a remarkably accurate indicator of changes in consumption levels and the prevalence of alcohol-related problems in Canada and elsewhere.

On the matter of the trend in the real price of alcoholic beverages, the Brewers have ignored the central issue in their "Observations". As we pointed out in our earlier response, the relevant economic factor from a public health perspective is the real price of alcoholic beverages sold for home consumption. The latter constitutes about 80% of total consumption and when alcoholic beverages are sold for this purpose, they are inevitably less expensive than when sold for on-premise consumption. In our original response, we provided tabulations showing the trend in the price actually paid by an Ontario buyer for some of the common beverages. These tabulations are reproduced again below. The figures speak for themselves.

Lastly, in their "Observations", the Brewers dismiss our more detailed explanation of the thinking underlying our recommendation for a moratorium. We have tried to state clearly that there is little direct evidence yet available respecting the individual effects of many control measures. Essentially, the situation is one marked by uncertainty. Under these circumstances, the only responsible recommendation seemed to us to be for a moratorium, which means no change — neither relaxation nor increased restrictiveness. One can only wonder what evidence the Brewers would cite to show that increasing availability further would be in the interest of public health.

Graph 1



Footnotes

†For example, Popham, R.E. 1956, the Jellinek Alcoholism Estimation Formula and Its Application to Canadian Data, Quart, J. Stud. Alc., 17: 559-93; Popham, R.E. 1970, Indirect Methods of Alcoholism Prevalence Estimation: A Critical Evaluation, In: Alcohol and Alcoholism, R. E. Popham (Ed.), Toronto: University of Toronto Press, pp. 294-306.

††For example, Schmidt, W. 1973, Analysis of Alcohol Consumption Data: The Use of Consumption Data for Research Purposes. In: Proc. Epidemiol. Drug Dep.: Report on a Conference, London, England, September 1972. Copenhagen; Wrld. Hlth. Org. (EURO) 5436-IV, pp. 57-66; Schmidt, W. 1977, Cirrhosis and Alcohol Consumption: An Epidemiological Perspective. In: Alcoholism: New Knowledge and New Responses. G. Edwards & M. Grant (Eds.), London, Engl.: Croom Hall, pp. 15-47.

Table 1

Consumer Price Indexes (1968 = 100), and the Price to the Consumer (excluding bottle deposit but including Ontario Sales Tax) of Canadian Beer and the Least Expensive Rye and Sherry in Ontario 1968-1977*

Year	Consumer Price Index for:			Dollar cost of:			
	Canada	Toronto	Toronto-Ottawa	12 small beer	24 small beer	25 oz. least expensive rye	26 oz. least expensive sherry
1968	100.0	100.0	100.0	2.30	4.30	5.00	1.00
1969	104.5	104.0	104.0	2.38	4.45	5.25	1.05
1970	108.0	106.7	106.9	2.41	4.50	5.25	1.05
1971	111.1	108.6	108.9	2.47	4.60	5.25	1.05
1972	116.4	112.9	113.3	2.64	4.90	5.50	1.20
1973	125.1	120.7	121.2	2.70	5.00	5.50	1.20
1974	138.9	133.4	134.0	2.92	5.35	5.90	1.40
1975	153.9	147.6	148.0	3.20	5.79	6.40	1.60
1976	165.4	158.4	158.9	3.42	6.24	6.70	1.60
1977	178.6	170.6	171.3	3.66	6.63	7.00	1.80
Percent Change	+ 78.6	+ 70.6	+ 71.3	+ 59.1	+ 54.2	+ 40.0	+ 80.0

*CPI's were obtained from: "Price and Price Indexes", Statistics Canada. The Toronto-Ottawa CPI was calculated by taking a weighted mean of the indexes for Toronto and Ottawa. The weights were 0.81337 and 0.18663 respectively. The dollar cost of beer is the weighted mean cost over the calendar year, taking into account the month when a change in price occurred. The data on beer prices and price changes were provided by Brewers' Warehousing Co Ltd, Nov 24, 1978. Rye and Sherry prices for 1968-1972 inclusive, and for 1975 were obtained from "Ontario Liquor Store Price List"; those for other years were obtained by phone on Nov 27, 1978 from Mr Jackman, Comptroller, LCBO.

Table 2

A Comparison of the Toronto Consumer Price Indexes for all Goods, Soft Drinks and Alcoholic Beverages, April 1973 - September 1978*

Year	CPI All Goods	CPI Soft Drinks	CPI Alc. Beverages
1973	91.4	80.9	95.2
1974	100.0	100.0	100.0
1975	110.7	121.5	110.0
1976	118.7	121.4	116.8
1977	127.9	120.9	123.2
1978	137.4	132.1	128.7
Percent Change	+ 50.3	+ 63.3	+ 35.2

*CPI's for all goods were obtained from: "Price and Price indexes", Statistics Canada; for beverages from: Mr H. Harnarine, Prices Division, Statistics Canada, (Information received December 7, 1978). The indexes for 1973 refer to the period April to December, and those for 1978, to the period January to September inclusive.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Alcohol: Drug Of Choice

Subject Heading: Alcohol and alcoholism overview.
Details: 25 minutes, 16mm, color, sound.
Synopsis: A history of alcohol use and prohibition shows that alcohol has been, and still is, the drug of choice for most people. Many adults are abusing alcohol to the detriment of their health, social life, family, and work. Treatment centres are reported to be grossly inadequate for dealing with the extensive problem of alcohol addiction. More attention is needed for treatment of multiple drug abusers. Recovering alcoholics describe some of the harmful effects of their excessive drinking, particularly the effects it has had on their relationships with their family.
General Evaluation: Good (4.0). An informative, realistic, and contemporary film, it was considered an effective teaching aid. The A/V group liked what the film said about alcohol and its abuse, and recommend public broadcast of the film.
Recommended Use: Likely to benefit general audiences of 12 years of age and older. Drug users and health professionals would also benefit from viewing this film.

Choice

Subject Heading: Attitudes and values, trigger films, youth and alcohol.
Details: 8 minutes, 16mm, color, sound.
Synopsis: With only musical accompaniment, bright colorful scenes trace various stages of growing up, from birth through adolescence, and into adulthood. These scenes depict people happily absorbed in healthy outdoor activities. Black and white stills of drug taking activities are interspersed in contrast with the happy events beginning with the teenage segment.
General Evaluation: Good (4.1). Contemporary, interesting, and well produced, with a clear message, and a strong emotional impact, this film was considered an effective teaching aid. Its length was judged suitable for most educational purposes. The film could produce attitudes opposed to drug abuse and help in decision making regarding drug use. Public broadcast was recommended.
Recommended Use: Likely to benefit audiences of 12 years of age and older.

Positions Available

MEDICAL DIRECTOR OF ALCOHOLISM THERAPY PROGRAM

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Chairperson, Search Committee
Department of Substance Abuse
2799 West Grand Blvd. — Office A573W
Detroit, Michigan 48202

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BOOK

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Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.

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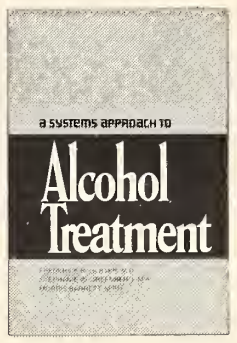

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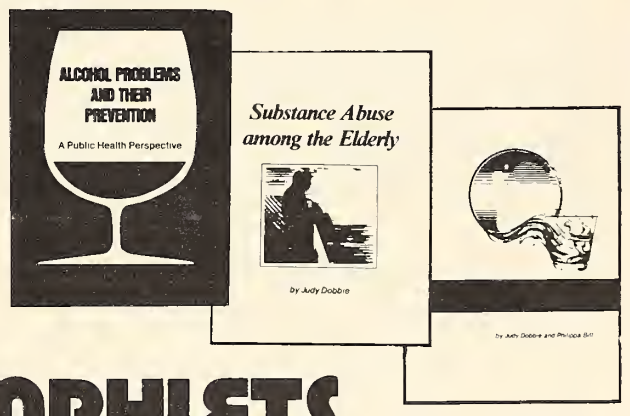
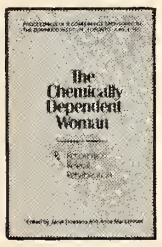


PROCEEDINGS



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(Plenum Press, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, M5S 2S1. 1978. 511p. $39.50)

The Art of Preserving Human Resources

. . . by Darrell D. Sorenson

In this book on employee assistance programs, the author evaluates various programs, then offers advice on how to sell the concept. He indicates unexpected barriers that could stand between the needs and a successful program. Planning, staffing, and the use of community resources are discussed and the role of company managers and labor union representatives is examined. The consortium is proposed as a method of delivering services for small companies.

(National Publications, PO Box 4116, Omaha, Nebraska, 68104. 1978. 93p. $4.95)

Other Books

Drugs, Alcohol And Women's Health: An Alliance of Regional Coalitions — Nellis, Muriel, coordinator. National Research and Communications Association, Washington, 1978. Reports and recommendations. Attachments include regional and state alliance representatives. 154 p.

Nonurban Drug Abuse Programs: A Descriptive Study — National Institute on Drug Abuse. US Dept of Health Education, and Welfare, 1978. Services Research Report. 27p. $1.20.

Cocaine And Other Stimulants — Ellinwood, Everett H., Jr. and Kilbey, M. M. (Jt. eds.). Plenum Press, New York, 1977. (Advances in Behavioral Biology — Vol. 21) Index. Includes papers with references presented at a conference on contemporary issues in stimulant research held at Duke U., Durham, N.C., Nov. 1975. 721p. $64.35.

Phencyclidine Use Among Youths In Drug Abuse Treatment — National Institute on Drug Abuse. U.S. Dept. of Health, Education and Welfare, 1978. Services Research Report prepared by the Philadelphia Polydrug Research Project based on 1976/77 National Youth Polydrug Study. 26p. $1.10.

Factors Affecting The Action of Narcotics — Adler, M. W., Manara, L., and Samanin, R. (Jt. eds.). Raven Press, New York, 1978. Monographed of the Mario Negri Institute for Pharmacological Research. Test subjects and methods, route of administration, Neurotransmitter modification of opiate actions. Environmental, pathological considerations. XXII, references, index. 774p. $35.75.

Alcoholism Programs In Industry: The Patient's View — Heyman, Margaret M. Rutgers, New Brunswick, 1978. Bibliography, index. Monographs of the Rutgers Center of Alcohol Studies No. 12. Appendix describes sampling, original interpretation of study and access to patients and records by individual program. XIV, 88p. $8.50.

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Canada

10th International Congress For Suicide Prevention And Crisis Intervention — June 17-20, Ottawa, Ontario. Information: Secretariat, IASP Congress '79, 700-71 Bank St, Ottawa, Ont, K1P 5N2.

70th Annual Conference Of The Canadian Public Health Association — June 18-22, Winnipeg, Manitoba. Information: Mr G. H. Dafoe, executive director, CPHA, 1335 Carling, Suite 210, Ottawa, Ontario, K1Z 8N8.

Summer School On Alcohol And Drugs — Aug 20-24, University of Calgary, Calgary, Alberta. Information: Alberta Alcoholism and Drug Abuse Commission, 812 - 16th Ave, SW, Calgary, Alberta, T2R 0T2.

Input '79 — 3rd Biennial Canadian Conference On Occupational Alcoholism And Drug Abuse — Sept 23-26, Ottawa, Ontario. Information: Input '79 Headquarters, Conference and Seminar Services, Humber College of Applied Arts and Technology, Box 1900, Rexdale, Ont, M9W 5L7.

Canada Safety Council's 11th Annual Safety Conference — Sept 30-Oct 3, Quebec City. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario, K1G 3V4.

United States

14th Meeting — Association Of Halfway House Alcoholism Programs — June 3-7, Lincoln, Nebraska. Information: AHHAP, 786 East 7th St, St Paul, Minnesota, 55106.

The 41st Annual Scientific Meeting Of The Committee On Problems of Drug Dependence, Inc — June 4-6, Philadelphia, Pennsylvania. Information: Dr Leo E. Hollister, Veterans Administration Hospital, 3801 Miranda Ave, Palo Alto, California, 94303.

6th Annual Puerto Rican Substance Abuse Conference — June 5-8, Santurce, Puerto Rico. Information: '79 Conference, National Association of Puerto Rican Drug Abuse Programs, 1766 Church St NW, Washington, DC, 20036.

Ohio Drug Studies Institute 1979 — June 11-15, Columbus, Oh. Information: ODSI Training, Division of Mental Health, 13th floor, Room 1346, 30 East Broad St, Columbus, Oh, 43215.

University Of Utah School On Alcoholism And Other Drug Dependencies — June 17-22, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, Utah, 84110.

Southern Oregon Institute Of Alcohol Studies — June 17-22, Ashland, Oregon. Information: Ruthanne Lidman, coordinator, SOIAS, 3355 View Drive South, Salem, Or, 97302.

21st Annual International School Of Alcohol Studies — July 15-20, Grand Forks, North Dakota. Information: F. Wittmann, conference coordinator, University of North Dakota, Continuing Education, Box 8277, University Station, Grand Forks, ND, 58202.

Annual Summer Institute Of Drug Dependence — July 29-Aug 3, Colorado Springs, Colorado. Information: Summer Institute of Drug Dependence, PO Box 2172, Colorado Springs, Co, 80901.

14th Annual Teenage Institute On Alcohol And Other Drugs — Aug 5-9, Gambier, Ohio. Information: Teenage Institute Coordinator, Ohio Department of Health, Division of Alcoholism, PO Box 118, Columbus, Ohio, 43216.

6th National Drug Abuse Conference — Aug 26-30, New Orleans, Louisiana. Information: NDAC '79, 115 S Chestnut Street, Lafayette, LA, 70501.

30th Annual Meeting Of The Alcohol And Drug Problems Association Of North America (ADPA) — Aug 26-30, Washington, DC. Information: Driscoll and Associates, 1925 North Lynn St, Suite 1001, Arlington, Virginia.

4th International Conference Of Therapeutic Communities — Sept 16-21, New York City. Information: Charles Devlin, coordinator, Daytop Village, Inc, 54 West 40th St, New York, NY, 10018.

Association Of Labor-Management Administrators And Consultants On Alcoholism (ALMACA) — Oct 2-6, Detroit, Michigan. Information: ALMACA, 1800 North Kent St, Suite 907, Arlington, Virginia, 22209.

Annual Meeting Of The Society Of Forensic Toxicologists — Oct 31-Nov 2, Williamsburg, Virginia. Information: Robert V. Blanke, Medical College of Virginia, MCV Station, Box 696, Richmond, Va, 23298.

National Conference On The Problems And Preventions Of PCP Abuse — Nov 3-4, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, Ca, 94117.

Abroad

International Conference On Animal Models In Alcohol Research — June 4-7, Helsinki, Finland. Information: John David Sinclair, Research Laboratories of the State Alcohol Monoply (ALKO), Box 350, SF-00101, Helsinki 10, Finland.

The 6th World Congress Of Acupuncture — June 17-22, Paris, France. Information: Pierre Bidault de Villiers, Service Presse "Mondial", 3 Ruse de la Grande Truanderie, 75001 Paris, France.

4th World Conference On Smoking And Health — June 18-21, Stockholm, Sweden. Information: 4th World Conference on Smoking and Health, c/o RESO Congress Service, S-105 24, Stockholm, Sweden.

25th International Institute On The Prevention And Treatment Of Alcoholism — June 18-22, Tours, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

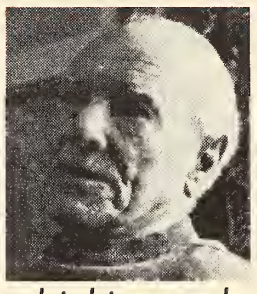
The 1st International Conference On First Aid At The Scene Of An Accident — June 19-23, Oslo, Norway. Information: The Norwegian Automobile Association, NAF, PO Box 494, N-Oslo 1, Norway.

6th Institute On Drugs, Crime And Justice In England — July 3-20, London, Eng. Information: Arnold S. Trebach, director, Institute on Drug, Crime and Justice in England, School of Justice, The American University, Washington, DC, 20016.

3rd World Congress Of The International Commission For The Prevention Of Alcoholism And Drug Dependency — Aug 26-31, Acapulco, Mexico. Information: ICAP executive director, 6830 Laurel St, NW, Washington, DC, 20012.

Muggeridge on fantasy and reality

__Malcolm Muggeridge,__ the ubiquitous British writer and speaker, was in London, Ont, this school year as journalist-in-residence at the University of Western Ontario. In an exclusive interview, with __The Journal__ he spoke to __Donald Gregory Bastian__ about the issues of drug legalization, the pursuit of fantasy, and the drinking problem in communist countries. Third in a series of International Year of the Child interviews.



Q: I have read that you stopped drinking and smoking in recent years. Had you been much of a user before then?

A: I have used them to an extent. I gave them up about 15 years ago, and I must say I've felt nothing but pleasure in having done so.

Q: Why did you stop?

A: The actual reason was that if you were holding forth against drugs, someone would inevitably say, well, but alcohol and tobacco are also drugs, do you indulge in those? I therefore felt I wanted to be able to say I didn't, so I stopped. I offer drinks to people if they drink. I don't think it is wicked — of course it is in excess — it's not a puritanical gesture on my part. But you can't really argue with young people, particularly about a thing like marijuana, if you are yourself taking drugs of a comparable nature.

Q: How did you come to this position about marijuana?

A: My feelings about it are so strong for a particular reason. When I was in my 20s, soon after I was married, I taught for a time in Cairo University and lived in the Middle East. It's extraordinary to think now, that at that time you wouldn't have been able to find anybody — European, Egyptian, anyone else — who would for a moment have thought there was anything good to be said about hashish addiction. You were surrounded by evidences to the contrary including, of course, the students at the university, who were occasionally stupefied with hashish and were utterly uncapable of learning or thinking or talking. So I was absolutely dumbfounded when, 40 years later, eminent people — doctors, nurses, researchers — actually said that it doesn't do any harm. And I noticed that in all the discussions of this — in the United Nations or the World Health Organization — that people in the countries where there really is an addiction problem, such as Pakistan, Egypt, and North African countries, are invariably opposed to the legalization of hashish.

Q: What do you think about the decriminalization or legalization of marijuana?

A: Whenever people are going to do something really crooked they invent a word for it — decriminalize. If you say legalize, it's giving the show away. But you decriminalize. It sounds very respectable. You know, you don't want to make people criminals, so you decriminalize them. The most hardened advocates of legalization then appear to be really humane people. But of course, decriminalizing and legalizing come to the same thing in the end. But I find it incomprehensible that you should have people, humane, good people, who will actually say that it doesn't do any harm.

Q: Did you have students in Cairo whom you saw on hashish?

A: Undoubtedly. They were zombies in the class.

Q: What led to their taking drugs?

A: It was the Middle East, where it's a common practice. And, for everybody at all levels of civilization and economic prosperity, there are times when they don't want to be aware of life and the drug provides a way out. They find that it's pleasant, and when life seems overwhelming, or maybe they're bored, they turn to it again. And they observe other people taking them. The kids are taking drugs because they observe others doing it.

Q: You taught in India as well as in Egypt. What were the differences in drug taking?

A: I was in Egypt in 1929, fifty years ago. India was longer ago. But in India, where I was, drug taking was not a problem. It was in Cairo, the Middle East, that it was a problem. And in Pakistan. I don't know why this should be so, but it is the case that it's liable to rise more in Moslem countries than in Hindu countries. Why this should be so, I don't know.

Q: There's quite a drive for teetotalism in India.

A: Very strongly. But not just a drive, it's absolutely the practice that all orthodox Hindus — especially Brahmans — won't take alcohol. And of course Ghandi was very strong on that also and his influence was very great. But drinking was rare to an Indian, except for a westernized Indian. All the vices in India that I came across were of people who were westernized. They copied this way of life of the west.

Q: How would you compare young people now, 50 years later, as you are working with them once again as a teacher? Do you see a great difference in matters of drugs and the way they're living?

A: Well, I do, because I think they assume that the promiscuous way of life and indulgence in marijuana is just part of the ordinary routine of existence.

Q: Do you find this is the case with alcohol also?

A: Yes. As it happens, I have never run across a drunk student, but in talking with students, it's assumed that drinking and promiscuity or, at any rate, love affairs, are quite accepted.

Q: Fifty years ago, all this was done, I suppose, but . . .

A: Well, it was done, but much less. When I was at Cambridge University, which was in 1920 to 1924, it simply didn't arise. There would be students who were debauched and who would seek prostitutes, but promiscuity as it's known today was unknown.

Q: It had no apologetic then.

A: None at all. In fact, quite the contrary. One of the things that kept one from unbridled license was the feeling that to make approaches of that kind to someone who was in the social circle of your family would be a most ungentlemanly, bad taste thing to do, for which, if you happened to do it, you would be full of apologies. Whereas now, as I understand it, you are full of apologies if you aren't promiscuous — if you don't make some gesture of that kind, you would have to apologize.

Q: But, you're looking back on a long life. Do you think people who are young now could come to these positions you've come to? Or is youth naturally a time of excess?

A: The last thing in the world I wish to seem to be is sort of holier than thou, a pharasaical person saying do this or don't do that. But they (young people) are products of the mores of this society. I've worked in the media a great deal. The media are systematically corrupting the young in particular, in the sense that they ridicule and disparage any sort of moral behavior.

To say that the media are on the side of the devil sounds like a rather excessive thing, but they are on the side of the forces that are corrupting this society. They delight in ridiculing the family, chastity, marital fidelity, all these. They're held up as being boring. There's a very good saying of Simone Weil, in which she says that in reality, nothing is more wonderful and beautiful and creative and exciting than good, and nothing is more boring and tedious and monotonous and tenth-rate than evil. But in fantasy, unfortunately, it's the other way round. The media traffic in fantasy, and in their fantasy world, virtue and goodness and faithful love are boring and outmoded things and all the excitement of life and fascination of life lies in evil. That is the view that is being presented in one way or another to the young people today.

Q: Do you think drug taking is prompted by this boredom?

A: These things are closely connected. Take, for instance, the view that sex without any reference to other commitments is an exciting and wonderful thing. Young people go for it and they are given every opportunity and inducement. They're told about contraceptives before they can read and are urged to experiment, a word, incidentally, that is used a great deal: Before I get married, I want to experiment. It simply means they want to be promiscuous. Well, they find that is totally unrewarding, emotionally, in every way. I think it's quite often then that they turn to drugs, to dull the feeling.

Q: Do you see drug taking as one step beyond a promiscous life?

A: I would think so. I was reading an article in the Toronto *Globe & Mail* (newspaper) that saddened me very much. It was about this incredible number of suicides among teenage children in Ontario, between seven and eight every week, with about 40 attempted suicides among the young. And I'm quite sure this is connected with what we're talking about.

Q: You have written of your earlier life as a life of dissipation. Do you mean that quite literally, or in a general sense?

A: I mean it literally.

Q: You were eating, drinking and being merry . . .

A: Well, I've never been for some reason interested in eating, so that wasn't true. Drinking, yes, only my drinking was, in a way, a very vicious kind because I only used to drink in order to be drunk. I never had any pleasure in drinking like people who make a lot of song and dance about wine and how beautiful it is. I've never been like that.

Q: Was this the extent of your dissipation?

A: And also womanizing to some extent. I wouldn't like to appear an example of virtue, but at least I say in light of all that, I'm utterly convinced that to legalize drugs is a wicked and sinful thing to do, and that alcohol, though it passes as being a kind of easy option, also causes endless pain and trouble to people.

Q: But do you think that withholding oneself from drugs and sex can be an uptight sort of thing?

A: Up to a half century ago and even less, people were withholding from drugs and promiscuous sex. Were we a collection of nuts and crazed people? We didn't have the sort of suicide rate you have here today. I've often said that if the promiscuous way of life produced glorious, happy, fulfilled kids, then I would have to say I don't like it and I don't approve of it, but I can't dismiss it. But it doesn't. It produces misery.

Q: You say you don't want to appear dogmatic or insisting that people live certain ways. But if you were to prescribe a remedy for youth who are bored and on drugs, what would you have them do differently?

A: I'd tell them that in this world you can only come to any true sense of direction in life if you are in contact with what is real rather than pursuing fantasies, and that you happen to live in a world that exploits fantasies all around you, fantasies which are calling in every direction. If you wish to find reality, I'd tell them, you can only find it in Christian terms.

Q: What should the pursuit be of, then?

A: Ultimately, it's the pursuit of God, the pursuit of reality. In that pursuit lies all fulfillment, lies the dedication of every single human faculty of mind, body, and soul. That's my opinion, and has been the opinion, not just of an old fellow like me, but of all the greatest minds and artists and the most considerable personages intellectually and spiritually of 2,000 years of civilization.

Q: What do you see as the main problem of the totalitarian world?

A: The problem for them is simply two things: One is, they can't relax the terror. If you rule by terror and power, you're imprisoned by terror and power. And secondly — and this is a rather ironical thing, really — they can't change. I first went to Russia in 1932, and I've been back from time to time, recently to make two television programs on Dostoevsky and Tolstoy. It's the most changeless society in the world. It can't change, you see, because they realize how revolutions happen. They are the most conservative; if they want to prevent all change taking place, they, paradoxically enough, have a revolution. They're imprisoned really in their own ideology even though they don't believe it any more. As soon as a dissident lifts his head, they have to either send him to a looney bin or to the gulag or out of the country. They can't have him there.

One advantage of our run-down world, decrepit democratic system that it is, is that we can change and we can get rid of a government and we can even survive crises. They (totalitarian states) can't. It's a monolithic power structure, and if one big crack appears in it, the whole thing will fall down. And I think that crack is appearing myself, in the communist countries.

Q: How do you see it?

A: In the sense that, first of all, nobody believes in the ideology, and, secondly, they've got a tremendous problem of drunkenness, caused by the strain of living in a uniform, boring, authoritarian world. The only thing you can get is cheap vodka. It's interesting that they provide it, almost as if they realize the people have to have some release. The real strength of the Russians is the utter weakness of the west, which is what Solzhenitsyn says. They have no strength to beat it. The same thing happened to the Romans: The barbarians never defeated the Romans; they simply moved in to a run-down derelict society, very similar to ours, with all this viciousness, these eastern cults, and the whole television industry, which is like their games — obsessive interests requiring huge amounts of money and consisting of the expectation of violence and eroticism. Even newspapers in the USSR have admitted the problem. When we were filming in Moscow recently, it was quite embarrassing at times. You simply had to be careful the people you were dealing with, not to go near them with the cameras. They were completely plastered. Right in the middle of the day. Any time. The drinking is fantastic there.

Q: The big push in China right now is for technological improvements.

A: And I'll bet you any money that, just as with Kruschev, there will come a certain point and the curtain will fall again. Because they can't allow it. From their point of view, it would spell the end of the whole thing. Now the Chinese have stopped opium smoking and this is an extraordinary fact. They've done it just by simply executing offenders. I've had this all described to me. A man pushing opium, using opium, possessing opium — he was shot. No trial or anything. And that stopped it. I knew China a bit before the revolution and you would have said it was almost impossible to stop opium smoking, it was so widespread. Well, they have stopped it. I suspect it might easily blow up again if things are relaxed. We could stop drug taking here, too, but the liberals would raise a mighty cry.

Q: What do you say about the view that by loosening up in our society on drug laws, drug-related behavior will become less neurotic?

A: It's extraordinary people should think that. They think that's why they have sex education. And in these suicides I was speaking about, there was never a suggestion by this team of psychiatrists — it fills me with horror; one psychiatrist is bad enough, but a team of them is a most terrifying thought — but the point is that it never seems to have occurred to them they ought to look into what sex education is doing. I'm sure what they'll come up with is that it should be earlier. And then it will cause more suicides and they will happen at earlier ages.

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The Journal

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Secret files

Laxity shocks privacy chief

By Jeff Carruthers

OTTAWA — Highly personal information from the federal health department's controversial illicit drug user data bank is being mailed to individuals without requiring positive proof of identity, **The Journal** has discovered.

As a direct result, and in direct contravention of the privacy provisions of the Human Rights Act, personal drug files have already been requested by, and sent to, people other than those named in the specific drug files, **The Journal** has determined.

This is the same information which federal health department officials last year maintained was so sensitive it should not even be made available to the one of every 100 Canadians who has a file, as required under the then-new Human Rights Act.

The fact the information is now being handled so loosely is bound to raise once again the issue as to whether the risks associated with the federal bureau of dangerous drugs compiling and maintaining such detailed information on known and suspected drug users is offset by the supposed benefits.

Even the possibility that personal privacy could be violated in this fashion (let alone that it should have already happened) came as a shock to federal Privacy Commissioner Inger Hansen.

Miss Hansen said Treasury Board guidelines have a general requirement that government agencies "verify the identity" of people applying to see their federal files "before" the information is released.

However, in an interview, she admitted that specific procedures have been left up to individual agencies.

(She also admitted she has no disciplinary powers, though she would like to know details of such problems so attempts can be made to tighten procedures for handling and dispensing such private information.)

The RCMP (Royal Canadian Mounted Police), one agency with information of comparable sensitivity to the health department's drug files, requires finger prints as proof of identity for people requesting a copy of their criminal record.

Miss Hensen said the RCMP policy, which she regards as a suitable attempt at balancing the right of an individual to see his or her file with the responsibility to ensure no one sees it, has already sparked some complaints from people wanting to see their criminal files without such fuss.

A. J. Liston, director general of the health department's drugs directorate in the health protection branch told **The Journal** the department has only had about three dozen requests for copies of drug user files.

Of these, 20 requests turned up no files and the individuals were so advised.

Fifteen requests were made by people with drug files.

In nine instances, additional information (such as date of birth) was requested by letter, to help ensure the person applying was in fact the individual named in the file.

When the additional information was provided, the files were mailed to the person listed on the formal request form.

Dr Liston later explained the department might require positive proof of identity, if officials considered the information sensitive enough. Mentioned was the possibility of requiring the file to be collected in person, such as at a regional office of the bureau of dangerous drugs.

To date, he said, this has not been required, although one individual voluntarily collected a file at a regional office.

By direct implication, the bureau of dangerous drugs has decided the information it has been mailing out is not that sensitive, at least so far.

Yet, **The Journal** has been able to ascertain the files can and do regularly contain information that could be embarrassing and even damaging if it fell into the wrong hands.

For example, almost all files contain details on drug convictions — the very information in RCMP files where finger prints are required as proof of identity.

Generally, the files contain information gathered from police, doctors, pharmacists, drug treatment clinics, and even disgruntled informants on known and suspected users and distributers of drugs covered by the Narcotic Control Act (including heroin and cannabis) and the Food and Drug Act.

The vast majority of the files — 191,591 at last count — cover known or suspected users of cannabis (marijuana and hashish).

The health department says it needs to keep the drug files so it can fulfill its mandate to keep up to date on drug abuse trends, and keep records on things (such as cars and money) seized in connection with drug crimes.

Some civil liberties groups have complained it is in fact dangerous and misleading to maintain cumulative drug user files, with people identified, especially on such a wide scale. They maintain nameless information would be just as good in most instances.

Under the Human Rights Act, every Canadian has the right to receive a copy of material relating to them and contained in various designated federal data banks, to ensure the information contained is accurate, and to request corrections of mistakes. Request forms, along with a listing of the more than 1,000 federal data banks, are supposed to be available at any post office. Several dozen data banks, mostly ones dealing with national security and criminal investigations currently underway, are exempt by special cabinet order from review even by named individuals.

The drug files were originally exempt in this fashion; however, Liberal Health Minister Monique Begin was finally convinced she had made a mistake in recommending the original exemption (based on advice from her officials), especially when it was discovered that RCMP data banks with much of the same information are open to review under the privacy provisions of the Human Rights Act.

'Alcoholism is treatable, beatable'

By Harvey McConnell

WASHINGTON — A new initiative which will inject a further $22 million for training, prevention, and treatment of alcoholism is being sought in President Carter's 1980 budget.

Joseph Califano, United States secretary of health, education and welfare (HEW), said the request is the largest in any budget since the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was launched. It brings to $175 million current HEW spending on alcohol programs.

Mr Califano told the annual conference of the National Council on Alcoholism meeting here that alcoholism is "Public Health Enemy Number Two," second only to smoking, and "it is not only a treatable disease, but a beatable disease."

Most of the additional funds will go into programs for specific population groups and problem areas.

To deal with problem drinking among teenagers and young people, $12.5 million is being asked for education, prevention, treatment, and research. Five comprehensive alcoholism prevention projects will be targeted at 750,000 young people with the help of the Boy Scouts, Girl Scouts, Catholic Youth Organizations, and others.

An information campaign to encourage sensible attitudes toward drinking among the 40 million young people aged 15 to 24 will be launched with an emphasis on automobile safety. "We must reduce the carnage on the nation's highways," Mr Califano said.

(Research on drinking and driving will become a major thrust of the NIAAA, new director John DeLuca has said. See interview page 4).

Mr Califano said $11.85 million is being asked for increased research into alcohol problems among women and to expand support for treatment programs.

A nationwide program of outreach will be launched about women and alcoholism involving industry, labor, voluntary agencies, and national women's organizations.

Research will be stepped up into the fetal alcohol syndrome, and efforts will be made to reach the 48 million American women of childbearing age warning them about the dangers of alcohol for the fetus.

Mr Califano said new efforts will be directed at alcohol problems among the elderly, Indians, and veterans.

Fifteen new programs costing two million dollars will be launched in medical schools to teach future doctors about alcoholism. Federally-qualified health maintenance organizations will be required to provide diagnostic and referral services on an inpatient or outpatient basis to their members who are alcoholics or alcohol abusers.

Mr Califano said major efforts will be made to protect the public against the special dangers of combining alcohol with other drugs.

Mr Califano: "We are increasingly concerned about the dangers of alcohol use in combination with certain other drugs, especially sedatives and tranquillizers. This 'combination abuse' can kill — and does kill — thousands of people each year.

Surgeon General Julius Richmond will issue a special advisory to all doctors warning them of the dangers of combining alcohol and certain drugs. The Food and Drug Administration will provide Mr Califano with a list of commonly prescribed drugs that may present hazards when used with alcohol and for which new labels may be required.

Mr Califano said he will start a program within his own agency to aid alcoholics, and will urge other Cabinet officers to start to strengthen efforts among other government employees. "We will begin by putting our own house in order, and boy, does it need to be put in order," he said.

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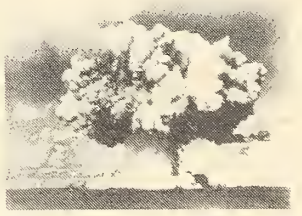

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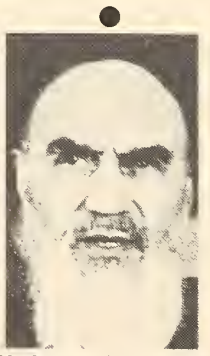

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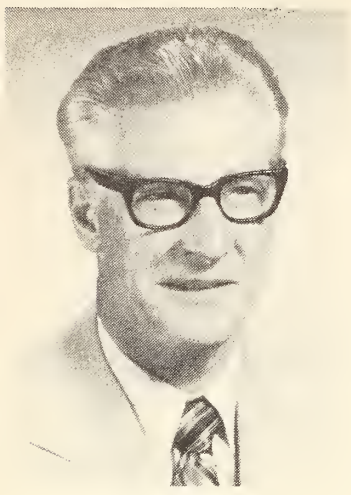


Kenneth Wylie

'Canadian physicians have been inclined to give too little . . . narcotic in . . . terminal cases.'

Canadians lead the world

Narcotic use up by 25%

By Betty Lou Lee

TORONTO — Total narcotic consumption, both licit and illicit, has risen 25% in Canada since 1971.

Canadians now lead the world in the use of codeine and hydrocodone, and are second only to the United States in consumption of oxycodone and pethidine.

The president of the Canadian Medical Association, Kenneth Wylie of Winnipeg, revealed the figures at the annual council meeting of the Ontario Medical Association here. He said that if all narcotics were converted to morphine equivalents, consumption has risen from 40 to 50 kilograms per one million population since 1971.

"Narcotic consumption is going down in most comparable industrialized countries such as Australia, United Kingdom, West Germany, France, Sweden, and Russia . . . Our consumption, and the rate at which it is increasing, is second only to the United States.

"As one of the country's leading clinical pharmacologists has stated, 'firm conclusions regarding whether this trend is good or bad cannot be drawn from the raw data and information now available'. Nevertheless, it is a matter of some concern to us."

One way in which the increase might be good is more narcotic use for terminal cancer patients.

"It has been recognized that Canadian physicians have been inclined to give too little, rather than too much, narcotic in serious, particularly terminal cases," Dr Wylie said. "As Dr Mark Nickerson so aptly puts it, 'Is addiction liability of any significance in treating a person with inoperable carcinoma of the breast or colon? It may be that the relative increase in legal narcotic use in Canada is an indication that North American physicians are taking note of the advice of our colleagues in clinical pharmacology — to give whatever is necessary to relieve pain'."

Other possibilities for increased consumption are less positive.

During 1977, there was a 29% increase in crimes to get legally produced narcotics for street use, Dr Wylie said, and preliminary 1978 reports indicate a similar trend.

"The diversion of narcotics for street use is a highly lucrative criminal endeavor. For example, one of the more commonly prescribed oxycodone tablets sells at the drug store for about 10 cents. On the street it sells for $40 to $50."

He wondered if there is medical justification or indication for cough and cold preparations that contain narcotics. "Is there any truth to the suggestion that some physicians have prescribed such products so frequently that they are guilty of 'contempt of familiarity,' that they have grown insensitive to the fact that they are prescribing narcotics?"

He wondered also if non-prescription drugs should contain codeine, and if some of these products should be available only on prescription.

Perhaps repeat prescriptions for products known to be misused, like hydrocodone and oxycodone, should be available only on written prescription. "Such increased controls would entail time-consuming administration, and related costs, for the physicians, pharmacists, and all concerned. Is the problem, or at what point is it, of such magnitude that it warrants such action?"

Dr Wylie said that some provincial pharmacare programs provide free prescription drugs that contain narcotics, but the patient has to pay for a non narcotic, comparable product. "Are physicians' prescribing habits influenced by the fact that the narcotic-containing products are available to their patients free? Possibly."

He said perhaps wide-spread pharmaceutical company distribution of samples of these products add to the problem. "Is there any need for extensive sampling of narcotic-containing products that have proven their value and effectiveness to the physician over many years?"

Dr Wylie said the CMA had asked for the advice and comment of Canadian medical specialty groups, and the situation was being studied by the CMA's council on medical services.

Alcoholics should abstain year before conceiving

WASHINGTON — Abstinence for at least one year before conceiving appears advisable for recovering alcoholic women, research at the University of Washington suggests.

A two-year, retrospective study by Ann Streissguth, PhD, and Ruth Little, PhD, found distinct differences in birth weight and intelligence quotients (IQ) between children of 50 controls, 50 recovering alcoholics, and 50 women alcoholics who drank during the target pregnancy.

Dr Streissguth told The Journal the women were matched as closely as possible, as were the offspring who ranged in age from eight months to 22 years. Most of the women were middle class, educated, and white.

She and Dr Little have found that there is an average 250g birth/weight difference between offspring of controls and recovering alcoholics, and a similar 250g difference between offspring of the recovering alcoholics and those who remained alcoholics during the pregnancy.

Neurophysiological testing found similar differences in IQs between offspring of controls and recovering alcoholics, and of recovering alcoholics and alcoholics.

However, Dr Streissguth said: "We have found that the longer the recovering alcoholic woman was abstinent prior to pregnancy, the higher the child's IQ. If they were abstinent for a year prior to conception, then there was a 10 point increase in IQ which is almost the difference between controls and abstainers."

Dr Streissguth emphasizes the findings are group data and there are extremely wide variations. "It does not mean that every mother who has stopped drinking just before conception had a child with a lowered IQ."

Other data from the study is still being analyzed. More reports on women and alcohol from the National Conference on Alcoholism will appear in the July issue of The Journal.

Departure in strategy

WASHINGTON — Heightened pressure on major drug traffickers and increasing emphasis on involving other countries in reducing supplies of illicit drugs at source are two major United States objectives in the coming year.

The federal Strategy for Drug Abuse and Drug Traffic Prevention 1979 says there is a need to coordinate domestic law enforcement, and treatment, rehabilitation and prevention, with international drug control so they become complementary.

The report by the Strategy Council on Drug Abuse presented to President Carter marks a departure from previous reports with less emphasis given to specific drugs and more to the economic aspects of trafficking, and a reliance on international organizations and foreign countries to help solve the problems.

Federal agencies, such as the Federal Bureau of Investigation, Drug Enforcement Administration, and US Customs Service, will concentrate on "investigating, arresting, and providing sufficient evidence to prosecute major violators of drug and drug related statutes, focusing on those traffickers at the top of the organization."

Financial probes, including attempts to seize assets, will be used against individuals responsible for drug trafficking who have so isolated themselves they do not handle the drugs personally.

On the international level, the strategy says US resources will be concentrated in four areas in an effort to achieve control objectives:

- Efforts to reduce illicit narcotic supplies at their sources.
- Participation in international drug control organizations.
- Cooperation with foreign narcotic enforcement agencies.
- International drug abuse treatment and prevention.

Brewers' experts lead king to 'higher ground'

By Wayne Howell

It was some years ago that an old fisherman casting his nets from the shores of the remote south seas island of Aku-Aku noticed a most curious phenomenon: year by year the Aku-Akuan beaches seemed to be getting narrower and narrower. When this was reported to the king, the jolly Polynesian monarch was not unduly alarmed — but just to be on the safe side he directed that measurements of the high water levels be taken. This proved to be a complicated endeavor for a variety of reasons but eventually, after a number of years, some statistics were produced. Imperfect though they were, they didn't look good, and so the worried king took up the matter with the visiting anthropolgist from the University of Toronto.

"You must realize," said the anthropologist after he had examined the king's figures, "that my specialty is polygynous matrilineal avunculocal cultures. But even to my untutored eye it appears that there may be Atlantisization factors operative — we'd better get this checked out." Fortunately the anthropologist had good contacts back home and within a week a group of Canadian statisticians were winging their way to Aku-Aku, courtesy of a CIDA (Canadian International Development Agency) development grant. The anthropologist was ecstatic.

"We're really lucky these particular chaps were available," he told the king. "These statisticians from the Ontario Brewers Association are the best in the business — why if it wasn't for their incisive analysis, ARF alarmists would have had the legislators of Ontario believing that the province was in danger of being inundated by alcohol."

When the statisticians arrived, the king passed them his collected data with trembling hands. He was scared. But the Brewers' statisticians were not at all alarmed.

"These figures prove nothing at all," they said. "It's truly a shame that you've got your people all upset about the possibility of the island sinking beneath the sea: looking at these miserable graphs and scribbles one could just as easily conclude the exact opposite — that the sea is rising to cover the island." The king felt better already: he was in the hands of people who knew what they were doing.

The statisticians unpacked their bags and settled in.

"First thing we've got to do," they announced, "is source these stats of yours." That was a new one to the anthropologist but the statisticians proudly explained that "to source" was a neat verb they'd invented while they were doing their bit for the Ontario Brewers.

"They're very creative people," the anthropologist told the king.

Unlike some CIDA volunteers who have been known to "go native" in exotic tropical locales, the Brewers' statisticians were all business: every day they could be seen on the beaches in question, sometimes paddling about in the surf, sometimes going for long walks along the shoreline in the company of their young guides, sometimes just lying on the beach making sophisticated calibrations with their eyes closed to prevent distractions.

After several weeks of intensive research they reported back to the king. And what great news they had to report. The statistics so laboriously gathered over the years by the simple fishermen completely misrepresented recent and future Atlantisization trends because the *falus*, the Aku-Akuan standard unit of measure, was imprecise, based as it was upon a portion of the king's anatomy that was subject to variation. They recommended that the king commence to gather statistics anew, based on a more accurate standard measure — the length of his foot, for instance. Only then could the so-called Atlantisization of Aku-Aku be objectified, and if objectified, quantified.

The king, who had been worried sick about the fact that the sea appeared to be rising at the rate of 18 *fali* a year, was greatly relieved. To celebrate he ordered a great feast: suckling pigs surrounded by hot coals were buried in the sand and a huge pot of native beer was brewed. It was the hot coals, not the festivities, that were dampened when what the Brewers' statisticians called a "standard deviation" of the tide appeared. But the beer pot was saved, the party moved to higher ground, and a good time was had by all. The Brewers' statisticians left in the morning, bedecked in flowered *leis*.

One year later, when fishermen reported that the sea was rising at the rate of 22 *fali* a year, the king laughed and told them to be unconcerned — *fali* were crude inexact units of quantification. He did, however, work off and on at developing more precise measuring systems. According to legend he was working on them right up until the end.

Travel Note: *The Aku-Aku reef, a skin-diver's paradise, can be reached by charter boat from Mahé Island, Seychelles. Day trip, including lunch and compressed air for two dives, 40 pounds Sterling.*

If you were in secret file...

By Jeff Carruthers

OTTAWA — What would you do if you were the one in every 100 Canadians with a file in your name at the federal bureau of dangerous drugs, one of the several hundred thousand Canadians suspected or known to use illicit drugs?

First, there's the curiosity to know what the government has on you if anything. Is it correct and complete?

Then, once you officially request a look and receive the copy of the file in the mail, there's the concern that it was all too easy.

You collect a form at the post office, fill in your name and address, insert the agency name (the health department, bureau of drugs) and the information bank number and name ("14086", drug investigation, users and distributors, files). You mark the boxes indicating you want to know whether a file in your name exists and, if so, that it be provided in the language of your choice. Then you send it off to the address listed in the yellow-covered index.

If you're clean, you get a notice back saying there's no file on record.

If not, you stand about a 60% chance of receiving a letter requesting a piece of additional information — your birthdate, for example — to verify you are who you say you are.

Having supplied the "proof," you receive photostats of your "file," including copies of some curious rectangular cards with holes punched around the edges. The meanings of some of the holes are easy to decipher, of others not so easy at all.

What would happen if you submited a request using the name of a friend (with permission)? Would you get it?

The answer, it turns out, is yes.

The same, it seems, is true if you request the file of a spouse, even if you sign your own name.

Or if you were to type in your name instead of sign it?

The worst suspicions are confirmed.

If it's that easy — only a birthdate for verification — what's to stop an employer or a credit checking agency or an insurance company (all of whom have your birthdate, social insurance number, and more) from gaining access to the same information?

Or another government agency, for that matter?

Ironically, when the fact that this kind of thing has already taken place, is made clear to the bureaucrats in Ottawa, their first concern is that someone might have committed fraud — not that their own system has failed, as some had thought was possible.

Even the privacy commissioner, who asks for specifics so she can track down the problem ("I need to know the details so I can determine what exactly happened"), admits she cannot provide protection from prosecution.

And there's an added problem: you believe there are errors of omission and commission in the drug department file — mistakes that would make a major difference if the file were to fall into other hands.

A moral and legal dilemma underscoring a much more basic problem: the more information the government keeps on Canadians, whether it be on the "undesirables" who use drugs, on the habits of its employees, or on the financial details of its taxpayers, the greater the dangers of privacy invasion associated with all the information in those data banks.

Court strengthens federal control of drug use

OTTAWA — The Supreme Court of Canada has blocked what had appeared to be an interesting loophole for Canadians indicted by the federal government for drug crimes under the controversial Narcotic Control Act.

In the process, the five-to-two Supreme Court decision has strengthened the federal role in controlling the use of drugs specified in the Narcotic Control Act, including the cannabis drugs. (Legislation promised in the earlier 1970s to move cannabis to the less-stringent Food and Drug Act must await a new session of Parliament.)

The decision also effectively entrenches the right of the federal Attorney-General to launch prosecutions for crimes under the Act, whether or not the provincial Attorney-General concurs.

And it has called into question whether the Narcotic Control Act is primarily prohibitive in nature and part of the criminal law or whether it is more general in nature, primarily intended to control proper use of various drugs.

Nine provinces had argued before Canada's top court that the federal government was infringing on provincial jurisdiction in charging by indictment Patrick Arnold Hauser for possession of cannabis for the purposes of trafficking.

The administration of justice in general and the launching of prosecutions under criminal law had to be undertaken by the provincial Attorney-General, they argued.

For a hundred years — until a little-noticed change to the federal criminal code a decade ago — drug prosecutions had been exclusively undertaken by the provincial Attorneys-General, often in cooperation with the federal Crown.

By Jeff Carruthers

While the man at the centre of the constitutional turmoil, Patrick Arnold Hauser, was obviously trying to side-step the federal indictment charge, the provinces (all but Manitoba) were concerned about the further erosion of provincial powers by the federal government.

In rejecting the arguments of nine provincial governments, the majority argued that "it would be a denial of the basic concept of federalism to permit the provincial authorities to have exclusive control of the enforcement of such legislation and the sole determination as to how and when the legislation should be enforced by institution of prosecution or against whom such prosecution should be instituted."

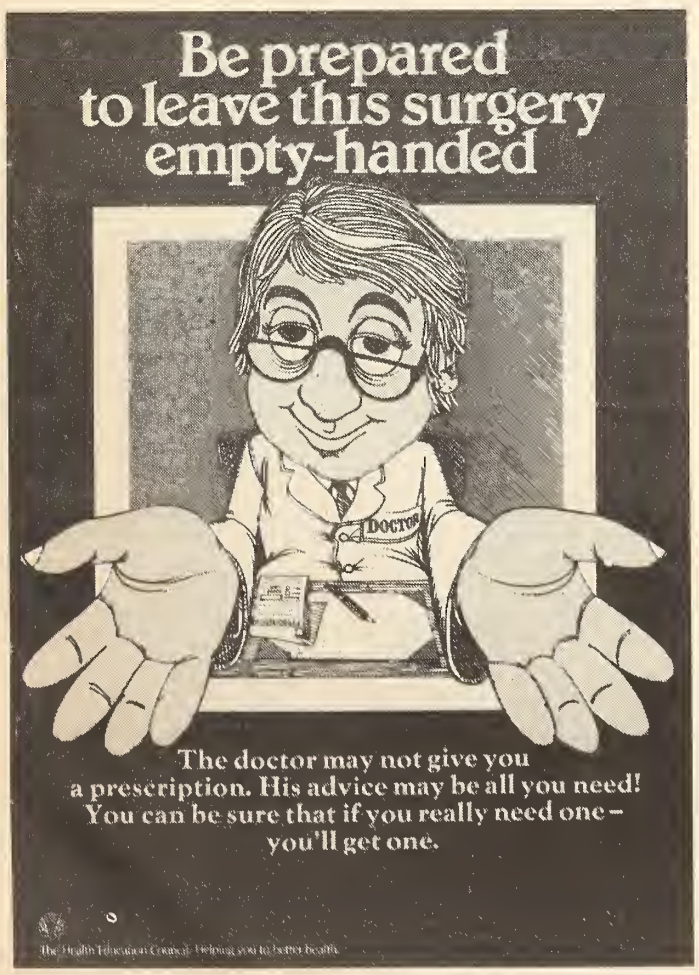
Justice L-P Pigeon, writing the majority decision, characterizes the Narcotic Control Act as being not only prohibitive in nature but also an essential element in a broader national attempt to control trade in drugs both legal and illegal that constantly cross national and provincial borders.

"It is apparent, in my opinion, that the regulation of the subject of narcotic drugs, the policy controlling their distribution, the investigation of breaches of the statute or regulations, and the institution of prosecution must be carried out by federal officials."

The majority also said that "the most important consideration for classifying the Narcotic Control Act as legislation enacted under the general residual federal power is that this is essentially legislation adopted to deal with a genuinely new problem which did not exist at the time of Confederation and clearly cannot be put in the call of 'matters of a merely local or private nature'."

In writing the minority position, Justice J. Dickson argues that the Narcotic Control Act clearly falls within the category of criminal law specified in the British North America Act (Canada's constitutional document) and that therefore the provincial supervisory power in respect of prosecution of offences under the Act must be maintained.

UK fights prescription misuse



LONDON — The Government's Health Education Council has launched a "Follow the Medicines Code" aimed at curbing the misuse of prescribed drugs.

It seeks to discourage the storing of medicines at home — thus cutting the toll of accidental poisoning, especially among children.

Among the code's major recommendations are:

- Never let a child get hold of medicines. They are often brightly colored and may be mistaken for sweets;
- Keep your medicine to yourself. Do not offer it to a friend;
- If you are advised not to drink or drive after taking your medicine, take the advice seriously.

Leslie Baines, chairman of the Health Education Council, said at the launching of the campaign that there were some 40,000 suspected poisoning incidents involving children in England and Wales every year.

Roughly half were attributable to medicines and drugs.

He said that the council hoped to dissuade the public from "demanding" prescriptions from their doctors. People should be prepared to leave the doctor's office empty handed.

Drug field 'hurt' by split

CHICAGO — A mission to try and reunite opposing forces in the drug abuse field in the United States has been undertaken by several people prominent in past National Drug Abuse Conferences.

This field was split last year (**The Journal**, May 1978) when a number of groups broke away from the NDAC, and decided to hold a National Drug Congress in Washington, DC. It will take place at the same time the National Drug Abuse Conference is being held in New Orleans.

Edward Senay, executive director of Substance Abuse Services Inc, told **The Journal** he, Dr Joyce Lowinson, and others plan to attend both conferences "with the aim of trying to pull together a coalition of people who will then reunite the following year. We are looking to the National Institute on Drug Abuse for leadership on this."

Dr Senay is in no doubt that the drug abuse field has been hurt, "and the funding sources must look on this with a jaundiced eye. I think there are a lot of people who regret the split now. It is beginning to dawn on them it wasn't a wise thing to do."

Drug researcher stabbed

TORONTO — The stabbing of psychiatrist and poly-drug abuse researcher, Donald Wesson, and his wife, and two children in Berkeley, Ca, has prompted action on the family's behalf by his colleagues in the drug field.

A reward of $2,000, has been offered for information leading to the arrest and conviction of the attackers who entered the psychiatrist's home at 5 am, April 24, and beat and stabbed Dr Wesson, his wife Sylvia, and their two young children, Ben and Shanna. All members of the family are now out of hospital.

Berkeley police are investigating the incident.

Colleague David Smith, founder and director of the Haight-Ashbury Free Medical Clinic, with which Dr Wesson is closely associated, called the attack "a very heavy personal tragedy," and said "there is a fear or feeling that this could happen to anyone."

Dr Smith and others have established the reward fund called Friends of the Wesson Family. Additional donations may be mailed to the Donald R. Wesson Reward Fund, 409 Clayton St, San Francisco, Ca, 94117.

'Communications deteriorating'

DeLuca heads NIAAA at critical juncture

By Harvey McConnell

WASHINGTON — Rebuilding communications with the alcoholism field and gaining respect within the United States government are the two major tasks John DeLuca feels he faces as new director of the US National Institute on Alcohol Abuse and Alcoholism.

He plans to reorganize the institute as well as to move it into new areas, such as the enormous problem of drinking and highway safety.

'Historical period'

Mr DeLuca said in an interview with **The Journal**: "This is a very historical period which the alcoholism field is entering. A lot of money has been spent on programs and a lot has been achieved.

"I truly believe the next stage is coming in the sense of the maturity of the institute as such, which has become very diffuse in its attempts to try to come into existence, develop itself, and to relate to others of its colleagues, if I can use a personal term, in the government."

Mr DeLuca believes the NIAAA must focus on critical recommendations on public policy "and take leadership stands where required. It has to set the example of excellence in this field."

He recognizes the NIAAA is at a critical juncture. "It has had a very deteriorating communications situation occur with the field itself, and it is not that well respected inside of government. I don't think that is any one person's fault, I think it is a natural occurrence because of a lot of other changes going on.

"But one of the most difficult tasks facing me as the new director is to gain respect for the institute internally, within the government."

It is still premature to talk of specifics, he said, but "I am hoping to make changes in the institute. I think there is some public knoweldge that there has been an extensive reorganization plan in existence, and one of my first tasks will be to look at that.

"I think there is every reason to assume there is going to be some kind of reorganization."

Some NIAAA staff may have become isolated, but there will be no wholesale sweep. "There are some very committed career civil servants in the institute. I think it is very important to leave intact systems that are working, and I think no one should fear changes or some new talent."

One of his key roles as NIAAA director will be to try and accomplish the translation of what is required into an acceptable form for those who, in a sense, can affect dramatically the key decisions or appropriations.

There are more and more demands for accountability and for facts and figures from government departments. At the same time, key public policymakers do believe alcoholism is a public health problem of enormous proportions.

Mr DeLuca said a major problem "which many of us in the alcoholism field tend not to want to talk about too much, is that it is difficult to reach out and encourage people to come in for treatment.

"It is hard to ask for money on one hand, and to be real honest about the fact that the most difficult task facing this field is to get people to come forward."

He believes the NIAAA must stimulate development of treatment systems: including treatment models, where treatment takes place, and how it can be cost effective and, at the same time, deliver quality care.

National policy

There is evidence treatment can take place in many environments, and there is a need to provide more access to care for the alcoholics and their families.

However, Mr DeLuca is clear on one point: "If we did this along traditional, high intensive psychiatric and medical models, we would break the bank. It is as simple as that.

"Since this disease responds to a variety of different approaches, and at different stages of the disease, we can possibly use models which are medically less intensive."

Another area to which NIAAA should devote a substantial amount of resources is developing a national consensus, or national policy, on alcohol, if that is possible.

Mr DeLuca also intends to move the institute into the study of alcohol and highway safety, "which has been an extremely neglected area. I think the institute has a leadership role to play and to seek some new solutions as to what we should do about it.

"It does not make rational sense that this society, all of us, accept the fact that many of us can step into an automobile while intoxicated and threaten each others' lives. In a sense, our system doesn't in any way constrain us from that.

"It is a preventable catastrophic event."

Whatever the solution, "it is clearly a role of the institute to play a leadership position and to work closely with other federal departments, especially the department of transportation. How to develop a policy on alcohol and highway safety is one of the crucial questions."

Part of the problem is, at what age should young people be allowed to buy alcohol.

Drinking age

Mr DeLuca: "My feeling on the drinking age is that we don't know enough yet to make what I consider to be really thoughtful public policy. There is some evidence that when the drinking age is lowered from 21 years down to 18, there is an increase in auto accidents and drinking among young people. Common sense tells us that.

"However, there is no evidence so far, to my knowledge, to support the idea that when the drinking age is brought back up to 21 you recover from having lowered it."

Raising the drinking age again might encourage disrespect for the law and create an era of illegal abuse.

Mr DeLuca believes age is not as important "as what people do with alcohol and what decisions they make. There are a lot of things we do as a society to restrain our freedom so we can live with each other, and we should look at alcohol and highway safety in that framework."

On the personal level, Mr DeLuca understands there is some opposition to his appointment. Questions are raised about his age and the fact he is the first director who is not a doctor.

As for his age, 35, he says with a smile: "I was beginning to think that at 35 I was getting pretty old, until just recently."

As for not being a doctor, "I think that at this point what is required is leadership at the institute. I wouldn't want to put it in terms of advantage or disadvantage; it is that the medical degree is less important and the management and public policy capability is more important and could be just as easily possessed by a physician or one who is not."

On opposition to his appointment: "It has been an intensely long search with all kinds of candidates, and it is bound to occur.

"There could not have been a single person who stepped into this directorship who would not have had controversy, in part because of the process used to find the person. It just took too long."

He is aware that while he did run the alcoholism program for the state of New York, "there are a lot of people who simply might not know me."

The only personal change he plans to make is to give up smoking in the near future.

Mr DeLuca says he believes that if alcoholism "is truly a major public health problem, and I truly believe it is, and I think the top policy makers in this country think it is, then it has to draw in as many talented people as it possibly can, on many different levels throughout the country, to work on it."

An immediate encouragement is the new initiatives announced by Joseph Califano, secretary of health, education and welfare, in the alcoholism field (see page 1).

Mr DeLuca: "His personal understanding, attention, and commitment to this has made it an extremely attractive opportunity. I hope to have an effect of creating more public understanding and comprehension of what has to happen."

One change for the NIAAA which Mr DeLuca does not see coming is merger with the National Institute on Drug Abuse (NIDA) or the National Institute of Health (NIH).

'Sudden surprise'

He explains: "I think there really is a nced to have a unique institute and there is going to be a need for that for a long period of time. I see the real long term future as being one where the alcoholic and his family are treated within the health care system (he favors national health insurance). I think until that occurs there is a need for categorical funding and there is a need for an institute which can work on specific treatment and development.

There are obvious points of cooperations between NIAAA and NIDA and NIH as they are all part of HEW, he said, but no merger is likely on the national level at present.

"And if the secretary has that in mind, it will come as a very sudden surprise to me."

BC heroin plan: 'experiment in mind control'

By Tim Padmore

VANCOUVER — It was one of the more bizarre attacks on British Columbia's much-attacked compulsory heroin treatment plan.

The charge: that the plan is an experiment in human mind control like the American CIA's (Central Intelligence Agency) notorious experiments with LSD and other drugs in the 1960s.

The scene: A hotel ballroom rented by the Citizens Committee on Human Rights of the Church of Scientology and the Ad Hoc committee against the heroin plan.

The big gun: Walter Bowart, author of the book *Operation Mind Control*, which documents CIA efforts to develop truth serums, amnesia drugs, aphrodisiacs, and loyalty potions.

Although Mr Bowart seemed a little vague about the BC legislation, appearing at one point to confuse the upcoming provincial election with some sort of referendum on the law, he didn't hesitate to make connections.

"If you pierced the veil, I think you would find that a lot of things that happened in the US are happening here."

He recalled what has been revealed of the CIA project MKULTRA, including LSD experiments on unwitting patients at a McGill University hospital.

He specifically cited the death of tennis pro Harold Blauer from an overdose of a mescaline derivative in a New York hospital.

"It sounds very much like your little drug program. It has the same built-in potential for abuse."

Seminar chairman Bruce Clark sounded the same note in an interview with **The Journal.**

"We can't sit here and say the Coordinated Law Enforcement Unit (a BC agency that enforces narcotics laws) is CIA backed, but," he said, "there are some parallel situations which don't make sense."

Why, he asked darkly, was there "this tremendous push" to put through the heroin plan in the face of widespread opinion that it would be a bad idea.

Press gets look at compulsory clinic

BRANNAN LAKE BC — It looks like a holiday camp — the indoor swimming pool, the gym, the green lawn down to the lakeshore.

You hardly notice the high wire fence and the mesh screens over some of the windows.

The scene is the province's new 150-bed heroin addiction treatment facility. Here, addicts will be detained under BC's compulsory heroin treatment act for up-to-six-month treatment regimens.

The centre officially opened April 1. Mid-month the Alcohol and Drug Commission invited selected journalists to tour the new facility, which has a staff of about 50.

There was only one heroin addict in the unit, which resulted in some bad feeling among the media. A CBC television crew interviewed Laurie, but others were turned away with the explanation that she was becoming nervous.

(At press time about a dozen patients had passed through Brannan Lake, the majority for detoxification from non narcotic drugs. One heroin addict had proceeded from detoxification to the main treatment program. One other addict, the only one committed through one of the evaluation panels established by the Heroin Treatment Act, was in hospital, having become ill while at Brannan Lake.)

The residences have brightly decorated individual cubicles grouped into six to 10 bed wards. There's a TV lounge, classrooms, and a woodworking shop.

Security consists of the fence and a 17-man unarmed security crew. They'll try to keep inmates in and drugs out, aided by daily urinalysis.

A small group of citizens opposed to the compulsory treatment attended the opening ceremonies and passed out leaflets. One leaflet was called Flowers of Buchenwald and compared the press tour to a famous Red Cross tour of Buchenwald concentration camp when inmates were forced to plant flowers and paint the buildings where they were awaiting extermination.

HEW plans marijuana research

WASHINGTON — A long range and broad-based research plan to study the effects of marijuana use is underway in the United States by the department of health, education and welfare (HEW) in light of the latest federal report, *Marijuana and Health*.

The study will involve relevant US health institutes and disciplines, and a review of the scientific literature. It is hoped this will lead to development of a scientific foundation upon which future national policy can be based.

Joseph Califano, HEW secretary, ordered the study following the dramatic rise in marijuana use, particularly by adolescents, noted in the report from the National Institute on Drug Abuse (NIDA) (**The Journal**, May.)

Mr Califano said until the review is carried out "we will continue investigations into the consequences of marijuana use, including the effects of long term chronic use, the effects of marijuana on the heart and lungs, on psychological, social, and physical development, and on pregnancy, as well as research into possible medical uses such as in treating glaucoma."

Robert Petersen, PhD, of NIDA, and author of the report, said while the public would like to have the health issues raised by marijuana use resolved unambigiously, "a recurrent problem is the limited number of new findings available to shed light on questions badly needing illuminations, but for which definitive answers are elusive."

Get tough with drunk drivers: OMA

TORONTO — Ontario's doctors want the government to get tougher with convicted impaired drivers.

At the Ontario Medical Association's annual council meeting here, it voted to urge the province "to deal more aggressively and severely" with such offenders.

But it referred to its board of directors another motion calling on the government to use some of its revenue from alcohol sales to finance a number of detoxification centres.

Dr Neil Finnie of Hamilton, who made the impaired driving motion, drew loud applause when he said such drivers should have "a threat over their heads of a major financial penalty and perhaps a jail term," rather than the present first offence penalty of a three month licence suspension, $500 fine, or seven days in jail.

But a number of his fellow delegates questioned both the effectiveness and appropriateness of the motion.

"This is a nice sort of motion, in line with hanging everyone who kills with a shotgun but doing nothing about the gun laws," said Dr L. J. Genesove of Willowdale.

"We live in a society which glorifies the consumption of alcohol, which maintains our entertainment and government on the proceeds of its consumption. We've gone from the ridiculous gangster days of Prohibition to free licence to get drunk as long as you don't murder someone with your car.

"We can't in conscience attack drunken drivers unless we look not at how we treat the alcoholic, but how we prevent and roll back alcoholism.

"I drink, but I would give up my right to tomorrow if I was convinced Prohibition would work. But there has to be some line between Prohibition and climbing up in that wonderful gondola and drinking a six-pack while you're at it."

The motion to have government liquor revenues help finance detox centres came from Dr D. M. Philpott of Orillia, who said the Simcoe County centre was closed for lack of funding, even though it was saving the province money on active and chronic beds. Active beds cost more than $100 a day, while detox costs were about $30, he said.

Alcohol control controversial in U.S.

WASHINGTON — America is not yet ready to consider controlling alcohol consumption by tax increases, one method of control suggested by work at the Addiction Research Foundation (ARF) of Ontario, believes Gerald Klerman, administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) in the US.

Dr Klerman said the approach associated with Schmidt, Popham, and DeLindt (of the ARF) "generates the most controversy" when the question of primary prevention and consumption is raised.

"I think it is worthy of further discussion, although I am not convinced this country is ready for enactment of a systematic excise tax," Dr Klerman told the annual meeting here of the American Medical Society on Alcoholism.

He said when primary prevention is mentioned to most doctors and laymen, including "in my experience members of Congress, or public officials, the immediate attention is to educational efforts directed at individuals or families. However, I think there are limits to which education can be the exclusive mechanism for primary prevention."

Dr Klerman said whenever the question of primary prevention and consumption is raised there is a great outcry and charges of "neo-prohibition."

"However, one cannot develop a comprehensive program for alcoholism without due attention, and a most difficult part of the prevention program is primary prevention. To develop a federal policy in primary prevention requires evidence of overall consumption of the population as well as significant subgroups."

He and the (US) National Institute on Alcohol Abuse and Alcoholism (NIAAA) do not advocate any form or prohibition, or of abstinence. "But if the price we pay for raising the issue again is to be labelled 'neo-prohibitionist' then so be it.

"There is very good evidence that a decrease in the relative price of alcoholic beverages is related to an increase in consumption, which is clearly related to an increase in health hazards."

A public health approach creates opportunities to look for collective efforts to influence problems, and the most controversial of these ideas is the work of Schmidt *et al* at ARF, he said.

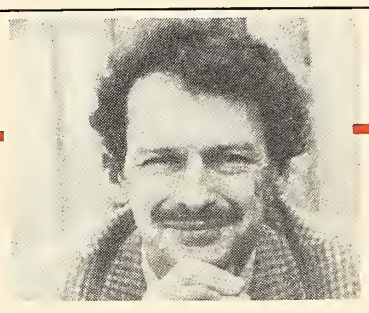
Dr Bourne UN water consultant

NEW YORK — Peter Bourne has been appointed a coordinating consultant for the United Nations Development Fund and the World Health Organization to help draw up a major program of worldwide water conservation.

Dr Bourne, who resigned in July 1978, as United States President Jimmy Carter's advisor on health and substance abuse matters, has signed a two-year contract with the UN. The program he is to lead will be called the UN Decade for Water.

Peter Bourne turns attention to worldwide water conservation for UN, WHO.

GILBERT



'Prevention has many paradoxes . . .'

Should we try to prevent drug abuse?

By Richard Gilbert

As a contribution to the planning of research on tobacco use in Ontario, I spent some of last summer classifying a substantial portion of the world literature on smoking into what I take to be the five most useful categories of research into drug abuse.

My data were the 1,091 papers, journal articles, book chapters, and other publications from across the world, abstracted during 1977 by the United States National Clearinghouse on Smoking and Health in their excellent *Smoking and Health Bulletin*. Of these, 101 items were not classifiable, because they dealt with tobacco growing, administrative problems, or some such peripheral matter, or because they were of such a general nature as to make classification impossible. I sorted the remaining 990 items into five *functional* categories, as follows:

Publications on the:	
causes of smoking	2%
consequences of smoking	80%
prevalence of smoking	4%
prevention of smoking	3%
treatment of smoking	11%

The categories are not mutually exclusive, but it was almost always possible to work out which one applied most aptly to a particular publication.

A functional classification gives us a reasonably good picture of what research in an area is concerned with, always remembering that the *number* of publications may not be a precise indicator of the amount of effort in a particular area.

The picture we get of smoking research is that the overwhelming bulk of the work is on the consequences of smoking, even though we now have a pretty good idea what the consequences are. The most authoritative statement on the topic, the 1979 US Surgeon General's Report, asserts: "Today there can be no doubt that smoking is truly slow-motion suicide."

Of course, items published in 1977 reported work planned in 1976 or earlier, and things may have changed. I surveyed 31 projects on smoking ongoing in Ontario last summer, and found the following distribution:

Research into the:	
causes of smoking	13%
consequences of smoking	55%
prevalence of smoking	10%
prevention of smoking	3%
treatment of smoking	19%

Compared with the earlier distribution, there appeared to be less emphasis on the effects of smoking, and more on causes and treatment, but still very little on prevention. A foreword to the US Surgeon General's Report noted: "Smoking is the largest preventable cause of death in America."

Prevention has many paradoxes. Consider the following: Canadian and US studies indicate that concern about health is the major reason for quitting. Popular awareness of the hazards of smoking has mushroomed during the past two decades. Almost all teenagers report being aware of the risks of smoking. Yet, in spite of this, smoking among teenagers continues to increase.

Thus there is little basis to the argument that work on the consequences of smoking is really work on prevention because knowledge of harm is a deterrent. Substantiating the hazards of smoking may help people quit, but it doesn't seem to stop people starting to smoke.

If preventing smoking is an objective of our society, there is an obvious need to discover how to do it. The discovery will likely be made only through a frontal attack on the problem, rather than through research into the causes and consequences of smoking, although there is no denying that knowledge about causes could make some contribution to the development of techniques of prevention.

It can be argued that unless society actually chooses to prescribe a drug, which has not yet happened with tobacco, people should be given an accurate balance sheet of the costs and benefits of using the drug, and left to make up their minds as to how to behave, at least in private. I agree with this position, as it applies to adults. Children are another matter. I feel that society has a greater obligation to protect the health of a child than to protect its freedom of choice.

Increasingly, tobacco use is a childhood phenomenon. For adults, the scientific community's concern for consequences is appropriate. For the sake of our children, we need to know more about prevention. The Year of the Child is a good time to start finding out.

Next month: Are alcoholics different from you and me?

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Guest Comment

Pot - induced brain damage real possibility

By Kevin O'Brien Fehr, PhD*

In a recent letter to the editor (**The Journal**, Apr) Mike DeVillaer states that Dr Norman Doorenbos failed adequately to substantiate his statement that "marijuana probably causes brain damage" (**The Journal**, Feb). The tone of Mr DeVillaer's letter, combined with the editorial choice of the caption, Pot brain damage alarm unfounded, imply that, indeed, the statement cannot be substantiated.

Mr DeVillaer is correct when he states symptoms of acute intoxication do not constitute evidence for brain damage. However, his assertion that the evidence supporting a cannabis-induced organic brain syndrome is "correlational at best" and confounded by unrelated variables, deserves comment.

I believe this complicated issue can be at least partially clarified by a brief review of the pertinent literature. Brain damage can be reflected by obvious changes in cellular architecture or ventricular size, by alterations in biochemical pathways, and by variations in brain wave (EEG) patterns. Often, however, the most sensitive indicators of altered brain function are subtle changes in behavior which may, or may not, be reversible.

Clinical reports from Eastern countries where the use of cannabis has been endemic for many centuries have often referred to a cannabis-induced "dementia" in long term heavy users of hashish. Similar descriptions have appeared more recently in European and North American literature and have given rise to such terms as "the amotivational syndrome" or, more colloquially, "burned out." The behavior of these heavy users is characterized by apathy, slowing and interruption of mental processes, difficulty with abstract thought, and impairment of memory and learning ability. The impression of many clinicians is that while much of the impairment is reversible when cannabis is discontinued, some of the changes in a few individuals may be permanent.

These clinical observations have been criticized as being "anecdotal" ie without proper quantitation or control groups. This is in spite of the fact they have been reported independently by many observers from several different cultures. It is interesting that equally "anecdotal" clinical observations of alcoholic dementia and amphetamine psychosis have never been questioned, and that the evidence for alcohol-induced liver cirrhosis is also "correlational at best" in that it has never been produced experimentally in humans.

Efforts to quantitate cannabis-induced cerebral deficits in long term heavy users of hashish in Jamaica, Costa Rica, Greece, Egypt, and India have produced inconsistent findings. The Jamaican and Costa Rican experiments used relatively small numbers of subjects (30 and 40 users respectively), and produced generally negative results. In the Greek study, also using a small number of subjects, the 46 cannabis users performed more poorly than a matched group of non user controls on 14 of the 15 psychological tests although the differences on each test were not always significant. However, the fact that the results of 14 of 15 tests favored the non users is, in itself, highly significant, and this point has largely been ignored.

Two of the collaborators in this study, Max Fink and Costas Stefanis, were apparently unable to agree on the significance of these results as they have subsequently published conflicting conclusions. Dr Stefanis states the poorer performance of the hashish users on psychological tests, as well as the higher incidence of paranoid psychosis and antisocial personality disorders in this group, are suggestive of cannabis-induced pathology. Dr Fink reported that the study found no evidence for brain damage. With that sort of contradiction, it is little wonder the public is confused.

In the largest experiment to date, Dr M. I. Soueif studied the psycho-motor performance of 850 presumably unintoxicated cannabis users and 839 non user controls all of whom were inmates of an Egyptian prison. Significant deficits were observed in the user group and were most apparent in the youngest, best educated, and urban subjects. Although the study has been criticized by the authors of the Costa Rican study, on the basis of poor experimental design and inappropriate statistical methods, the same pattern of results emerged when the identical test battery was repeated with heavy cannabis smokers in India. Clearly, these results must be examined closely before the possibility of impaired brain function can be dismissed.

There have also been attempts to correlate behavioral changes with measurable changes in brain anatomy. In 1971, Dr A. M. G. Campbell and his co-workers reported they had found significantly enlarged lateral ventricles (and hence, cerebral atrophy) in 10 young cannabis users complaining of headache, impaired recent memory, poor concentration, and depression. These findings elicited a storm of protest largely centered on the experimental techniques (pneumoencephalography), the lack of an adequate control group, and the fact that all of the subjects were polydrug users, and many had a history of head injury. Two attempts to replicate these results using the new technique of computerized tomography have failed to demonstrate cortical atrophy in young American cannabis smokers. This is not surprising since it is known that deficits in performance can occur in the absence of cerebral atrophy. Since systematic autopsy studies on the brains of cannabis users have not been reported, it is unknown whether changes in cellular structure or biochemistry occur in these individuals.

The EEG studies in humans are also largely inconclusive. For ethical reasons, experimenters are limited to surface electrodes in humans, and recordings from these electrodes appear on visual inspection, at least, to be unaffected by chronic cannabis use. In a study of 18 unintoxicated chronic marijuana smokers at University of California at Los Angeles, however, Dr J. Hanley, using a sophisticated computer analysis of the EEG recordings, found that the computer could distinguish the recordings of the users from those of a matched group of non users with 90% accuracy.

All of the human studies have, to some extent, suffered from deficiencies in experimental design. In most of the so-called "foreign studies," the number of subjects was so small that effects occurring with a frequency of 5% or less would probably not have been observed. Psychological tests standardized in North America were translated and applied to poorly educated and culturally different populations. Subjects were matched with non user controls on the basis of age, socioeconomic status, etc *after* several years of cannabis use. If the cannabis use adversely affected the variables on which the subjects were matched with non users (eg socioeconomic status), then *post hoc* matching would have eliminated many of the differences between the groups. A recent American estimate of the cost of the huge prospective study required to eliminate this problem was $2 billion, an amount of money currently unavailable.

For these reasons, investigators have attempted to study the question of cannabis-induced brain damage using animal models free of the factors such as malnutrition, infection, cultural differences, and polydrug use that confound human studies. The evidence in animals is more clear cut.

In our laboratory at the University of Toronto, Dr Harold Kalant and I exposed rats for six months to a dose of cannabis extract sufficient to keep the animals intoxicated for several hours each day. This dose is known to produce blood levels of Δ^9-THC (the major psychoactive ingredient of cannabis) in the rat similar to those observed in humans who smoke large amounts of cannabis. Several months after the end of treatment, these animals were less able than untreated controls to learn new tasks such as maze running or treadmill pacing. In addition, a large proportion demonstrated abnormal predatory behavior. These behavioral changes were accompanied by long term EEG alterations in the hippocampus, an area of the brain known to be important in learning. Changes in this area of the brain cannot be studied by conventional EEG techniques in humans.

Similar residual EEG changes have been reported by Dr R. G. Heath and associates in rhesus monkeys treated for six months with cannabis smoke. No investigator has ever described residual decreases in brain weights or any other signs of gross cerebral pathology. In a recent electron microscopy study, however, Dr Heath's group, using the same monkeys, did observe alterations in the synapses, including a widening of the synaptic clefts in the one area of the brain they examined. This change might, theoretically, impair the transmission of messages between neurons.

Equally significant is a growing number of studies describing behavioral changes in offspring of animals treated during pregnancy with cannabis in doses lower than those required to produce congenital abnormalities. For example, Dr P. Fried observed delayed development and reduced activity in rat pups whose mothers were exposed to marijuana smoke. Given the fact THC is known to have an affinity for fetal brain, and can impair the synthesis of macromolecules such as proteins, DNA, and RNA, it could be that prenatal exposure to marijuana poses a greater threat of subtle brain damage than of more obvious birth defects.

It is important to emphasize that any single study rarely provides a definitive answer to an issue of this type. It is the cumulative weight of the clinical, experimental, and other evidence that is important. Clearly, the animal experiments, while not providing absolute proof of the occurrence of cannabis-induced brain damage in humans have, in addition to the observations in humans, struck a definite warning note.

On the basis of current clinical and experimental evidence, Dr Doorenbos' comment that "marijuana probably causes brain damage" is the most conclusive statement any scientist can make at this time, and I, like an increasing number of other investigators, agree with him.

Hopefully, further use of both human and animal studies will help provide answers to the many questions that remain. For example, what is the dose and duration of exposure necessary to increase significantly the risk of damage? To what extent are the observed changes reversible? Are some users more at risk than others and, if so, why? Do other factors (such as the use of other drugs) increase the risk in some individuals?

(Dr Fehr is a scientist in the documentation unit, Addiction Research Foundation (ARF), Toronto, and co-author with Oriana J. Kalant and Diana Arras of an annotated bibliography, Cannabis and Health Hazards, *to be published by the ARF soon. References for all of the material cited in this column will appear in that publication.)*

Dr Doorenbos' comment that 'marijuana probably causes brain damage' is the most conclusive statement any scientist can make at this time . . .
. . . Kevin Fehr

Editor... Letters to the Editor... Letters to the Editor...

In alcoholism, psychosocial bias is sensible

An article entitled Alcoholism an inherited disorder? (**The Journal**, April), described a study in which adopted children of alcoholics showed a significantly higher incidence of alcoholism as compared to control adoptees. Dr Swinson interprets this finding as evidence for a genetic factor. However, I would like to suggest some alternatives to this interpretation.

First of all, if the identified alcoholic parent is the mother, and if she drank during pregnancy, the drug would cross the placenta and enter the bloodstream and, eventually, central nervous system of the fetus. This might be the mechanism by which the child is predisposed to becoming alcoholic. Clearly, genes would play no role in such a mechanism.

If the father was the identified alcoholic, then it is possible that the mother, even though not identified as an alcoholic, still may have drunk during pregnancy and thus predispose the child to becoming alcoholic. The control group would not control for this factor since it is possible the wife of an alcoholic is more likely to drink during pregnancy than the wife of a non-alcoholic. Thus, the adoption studies have not controlled for the maternal environment variable (the mother's biological state during pregnancy).

There is a second alternate explanation. Heavy alcohol consumption by either parent may have a deleterious effect on sex cells which then predispose the offspring to becoming alcoholic. Thus, the transmission is made by way of mutation, rather than by way of a Mendelian mechanism. In this case, although the genes are involved, they are certainly not the origin of the transmission. On the contrary, an environmental variable, that is, heavy drinking by the parents, is the initial and key factor.

These other interpretations of the research create some problems. In the first one, the maternal environment factor can only be assessed by performing embryonic transplants and strictly controlling the substance intake of the mother. This is not likely to be done with human subjects for obvious ethical reasons. There is currently no known way to resolve the dilemma posed by the second option.

While it appears there is a PRENATAL factor involved in determining alcoholism, there is, after two decades of investigation, absolutely no evidence whatsoever for a genetic origin. It is only one of several possible interpretations of the researeh findings, and all the adoption studies in the world, no matter how strictly controlled, will not eliminate the confounds. In other words, we simply cannot distinguish genetic and environmental influences on a behavioral problem such as alcoholism.

Dr Swinson has criticized the prevalent "bias" of a "psychosocial explanation for almost everything." However, given the undisputed role of psychosocial factors in determining alcoholism, and our inability to prove a genetic origin for the problem, it would appear to be the only sensible "bias" to hold.

Michael De Villaer
Addiction Research Foundation of Ontario
Hamilton

Hong Kong addiction not *1 in 16*

An article New Neuro-therapy for drug addiction under UK scrutiny (**The Journal**, May, 1978) has just come to my attention. It described an acupuncture and electro-stimulation clinic which had been opened in England by Dr Margaret Patterson, who originally learned the techniques whilst serving as an assistant to Dr H. L. Wen in the Kwong Wah Hospital in Kowloon in 1972/73. Included in the text was the following:

"Dr Patterson was practising as a surgeon in Hong Kong when she first became aware that patients given anesthesia with an electro-acupuncture machine were freed from withdrawal symptoms if they happened, coincidentally, to be drug addicts.

"Hong Kong is possibly the only place where such an observation might occur since one in 16 of the population is addicted to either opium or heroin to some extent."

Hong Kong's present population is calculated to be about 4.6 millions, so one in 16 would represent a total of 287,500 addicts.

The only appropriate comment on such an estimate is that it is sheer fantasy. The Central Registry of Drug Addicts, which began operations Sept 1, 1976, and produced its first computerized report in October 1978, together with other fact-based indicators, now allows us to state, with some certainty, that Hong Kong's drug addict population is below 50,000 and possibly well below. I consider it to be within the range of 35,000 to 50,000.

I thought you would like to be aware of current developments in our data base.

Peter E. I. Lee
Commissioner for Narcotics
Hong Kong

Will-power alive / well

I would like to reinforee the recent article, It's Good to go it alone, re: Millicent Buxton (**The Journal**, Apr).

Early in my experience in alcohol programs I kept hearing casual remarks by clients and others that they had a friend or relative who used to have a drinking problem but quit "on their own." Later, I discovered an intriguing bit of research, *Changes in the Patterns of Alcohol Use Without the Aide of Formal Treatment: An Exploratory Study of Former Drinkers*, by Barry S. Tuehfield (NIAAA, 1976). The results of this study indicate that there are likely a great many people who have had quite severe drinking problems, and they have found ways to quit drinking or to attenuate it, without having recourse to formal treatment modalities, including AA (Alcoholics Anonymous) and pastoral counselling.

Serious drinking problems were resolved by making use of informal resources (reinforcement from family and friends) generally within the context of a relatively stable social and economic support system. Past experience with behavioral self-control (eg successfully quitting smoking) appeared to be helpful.

With our current strong economic and political investments in treatment, small wonder we hear little counter-propaganda that one can indeed do it on one's own.

The sloganeering about the necessity of treatment may even be counter-productive in many instances by creating an ever-more dependent clientele and eroding the capacity and inclination for those with alcohol problems to engage in that complex set of behaviors which used to be known as "will-power."

But I would insist that there is overwhelming evidence that drug dependent individuals can, so to speak, do it on their own quite successfully, and without engaging in any of the highly touted therapeutie rituals.

Mark Worden
Director, Douglas County Council on Alcoholism
Roseburg, Oregon

Letters with-held

Debate about the effects of second-hand smoke on health has grown fractious. Richard Gilbert's column in The Journal (Feb). Snuffing the myths of second-hand smoke, aroused the ire of the Non-Smokers' Rights Association (NSRA) which drew media attention to the question in presenting Dr Gilbert with their "Boner Award." The Journal has now received a lengthy letter from the NSRA commenting on the column, among other things; and a response from Dr Gilbert.

This page was to have been devoted entirely to the NSRA letter, signed by executive director, Garfield Mahood, and his medical advisor, Dr David Stewart, and the response from Dr Gilbert.

At press time, however, we were advised the NSRA is considering instigating a libel action against Dr Gilbert in connection with a letter published over his name in the Toronto *Globe and Mail* (April 21, 1979) on the same question. The letter that was to appear here from Dr Gilbert might possibly be construed as containing sentiments similar to those in the April 21 letter. Also, it is possible Dr Gilbert will have to consider launching a counter-suit.

The Journal's objective is to publish news and opinions about addictions. Expressions of opinion on matters other than addiction and that are potentially libellous serve neither The Journal's purpose nor The Journals's readers. At least until the legal questions are resolved, it will refrain from publishing either letter.

Drawing out demons: kids and art therapy

Art therapy is proving to be strong medicine against the mixture of anxiety, frustration, and hostility that makes drug-taking almost irresistible for youth in the barrios of Los Angeles County.

More than 350 students, Grades 4 to 11, are participating in 40 "Art Rap Groups" there, directed by Bobbi Stoll, a "clinic-affiliated, over 30-year-old, WASP female psychotherapist," as she describes herself. (She says it is a profile that does not immediately inspire the primarily Hispanic students' trust in her.)

Ms Stoll guides students from their initial graffiti-like works through to projects that bear the mark of individual personalities, thereby countering with imaginative expression the tragedy that often surrounds their lives. The samples of her students' work on these pages reflect this progression.

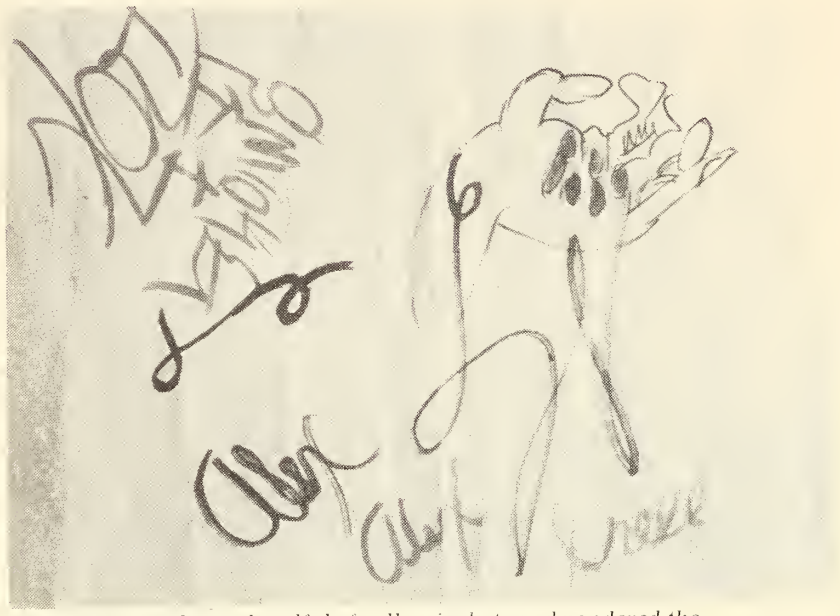
Through the students' graphic output, she says, it is possible to "assess areas of strength and weakness, the nature of their interpersonal relations, their means of coping with stress, and the level of their fantasy life — whether rich or impoverished."

The artist is engaged in self-discovery and is challenged to recognize unconsciously-held conflicts. Verbal associations to the art are encouraged. While they are less threatening than directly talking about oneself, these associations require self-confrontation.

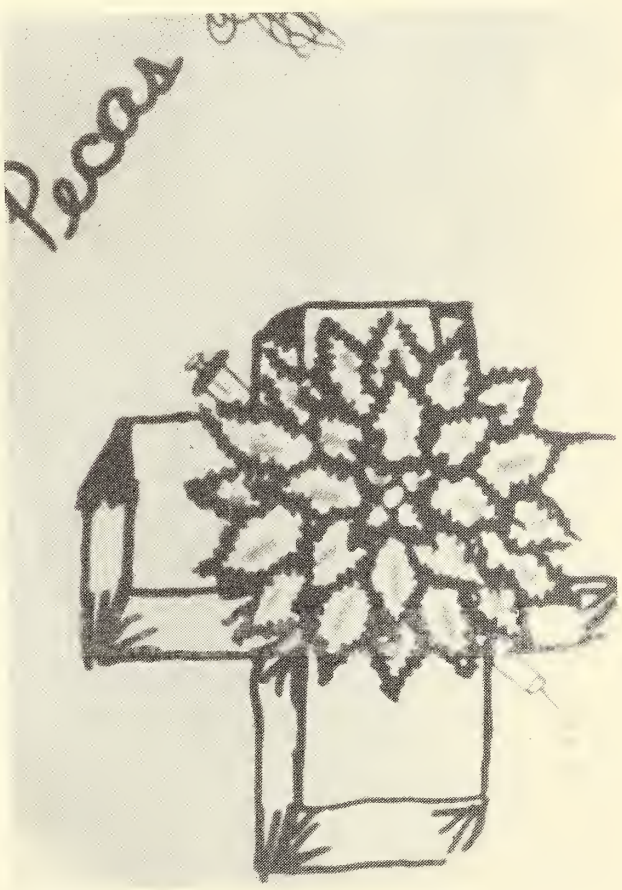
Ms Stoll herself paints a grim picture of the environment of her students. The families are terrorized by street crimes and violence. Some of the families are broken by divorce, separation, or imprisonment. The norm is a struggle to survive in low-income, crisis-ridden and agency-dominated lives through extended family grouping. Intact families are often over-protective.

While she does not claim it is easy to determine pre-drug-taking characteristics through art therapy, nor that the rap groups always prevent or successfully treat drug addiction, she does say "a picture is indeed worth a thousand words", and that the words these pictures prompt bring her closer to solving the problem.

Ms Stoll is a registered art therapist with a private practice in Beverly Hills, California. She directs the art therapy groups in conjunction with the Los Angeles County Department of Health Services Drug Abuse Program.

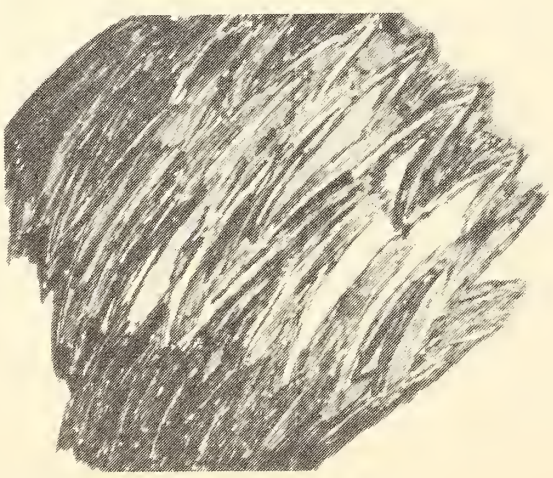


Alejandro, 14, drew a handful of yellow-jackets and pondered the question: "To gulp 'em or dump em," concluding that either way he'd end up with "an empty hand." It remained for him to find something to hold onto that was more personally gratifying than his drug habit.

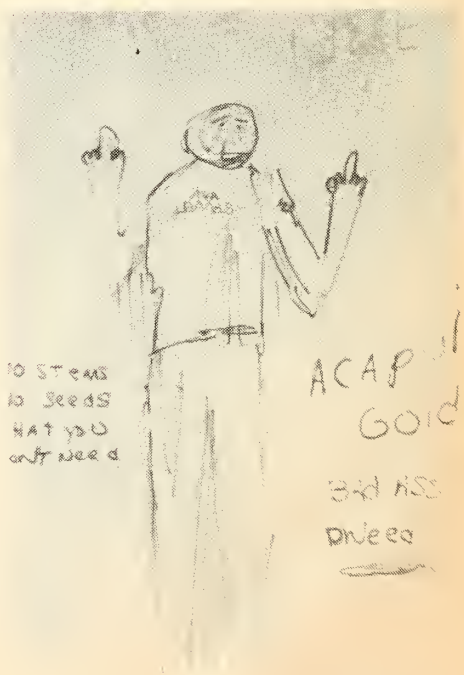


The cross is a cultural stereotype to which Suzanne, 15, added the needle to symbolize the loss of a friend who overdosed on heroin. Having thus revealed her pain, she spent many sessions expressings her feelings about her deceased friend and evaluating her own life goals.

Grace, 13, looks at cause and effect as she evaluates the consequences of her erratic multi-drug use. Her comment: "I'm in the box, the only face around is the drug demon with his awful laugh. My friends (the two small, faceless figures of friends attending her burial) don't matter now." Grace recognized the social implications of her drug use — a way to be with friends.

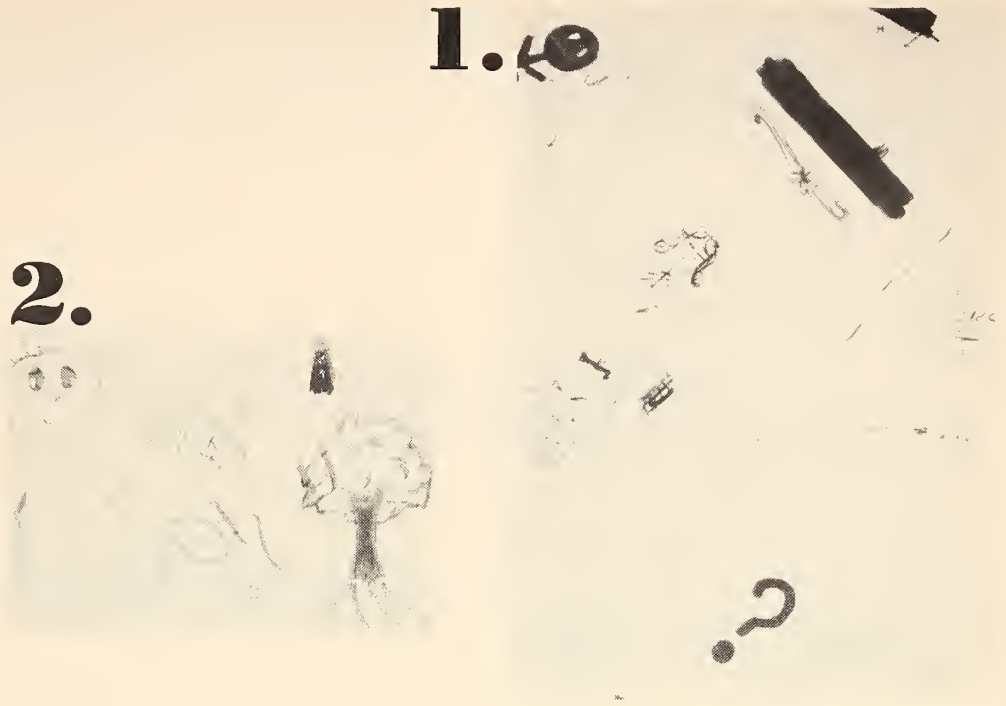


Vicky, 12, angry during a group session, described her scribbles as "some weed to make it settle down."



Mario, 13, — "Bad Ass Dweed"

Ruben, 17, who has realistic hopes for an art school scholarship, reveals his creative block and emotional conflict. He started an abstract drawing, upper left, but began protraying his mother who had overdosed on "reds" three years earlier. He had his own habit of "reds" and doubted he could stop without help. He also recognized his need to know his mother's motives and a stronger tendency to join her in death. He continued to use "reds" in both art and reality but began a series of paintings at home — all of his mother — in an effort to understand, unleash his own potential, and complete his unfinished grief. He recently expressed a desire to enter a detoxification centre.



This series of three pieces by Gina, 15, portrays her search for goals, values, relevance.

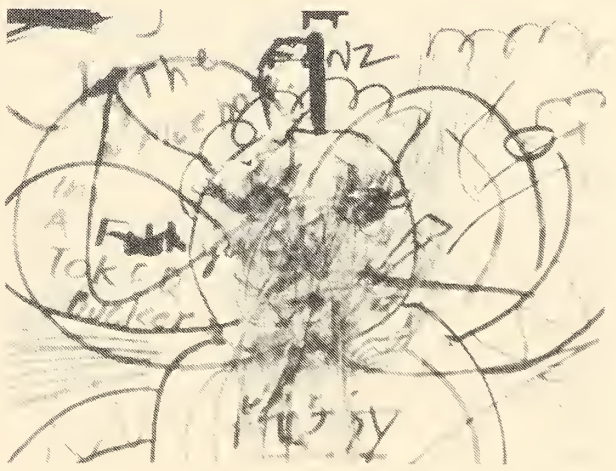
(1) The unanswered questions: Who am I? and Where am I going? caused anxiety too intense to handle without accompanying thoughts of drugs and suicide.

(2) Here drugs were offered as a means of adding color to her life as she chides herself to "be colorful" by using pot and angel dust.

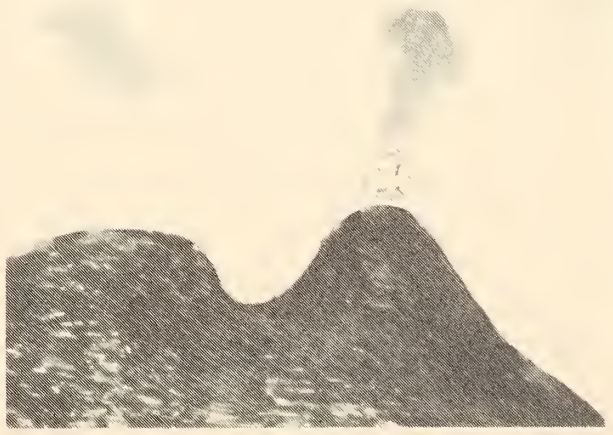
(3) "The Joy of Living Something You Can Stay With" a collage produced nine months after the first is the culmination of her search for answers to her questions. She has formulated some values and said of the work: "It's full enough and has enough stuff to think about some more. There's no room for drugs and they'd just wipe out all the rest anyway."

Enrique, 13 — "I can fly, but I sure look silly."

Juan, 17 — "That's how it is, man, with dust. I can take on anybody."



These drawings done seven months apart show nine-year-old Jorge's progress in controlling impulsive behavior. First is a self-portrait drawn by the fighter he was. He spit on the drawing and destroyed himself in the portrait. In the second, Jorge succeeded in expressing his aggression in the well-controlled but heavy coloring of the (red) mountain and is his displacement of focus from hands to feet as he drew himself atop the mountain with very large threatening hands but called the picture "Big Foot." Between these two extremes, Jorge produced many works which he kept together, and from which he gained a sense of satisfaction and accomplishment.



NATO nuclear troops under fire for drugs

By Thomas Land

BONN — The United States Army in Europe has declared war on drugs; and it wants to persuade other national forces within the North Atlantic Treaty Organization (NATO) to follow suit.

An inquiry initiated by President Jimmy Carter in Washington may well probe the effect of private lives on the combat readiness of troops manning US bases around the world, although the present campaign is concerned primarily with forces in Western Europe.

Together with their Canadian and European allies, the Americans face a numerical superiority of Warsaw Pact armies across the Iron Curtain. The entire military theory supporting NATO's European defence plans is based on the assumption of higher morale, combat readiness, and technological potency of Western troops.

Disquieting signs

That theory has come under serious scrutiny over recent years. One essential aspect of the doubts about NATO's credibility in Europe is supported by disquieting signs of a high level of drug abuse by North American troops this side of the Atlantic.

The psychological pressures under which they function in circumstances apparently divorced from the reality of daily life go a long way toward creating the conditions for drug abuse.

They face a fist-shaking enemy who has not, in fact, moved across no-man's-land for decades. They are asked to defend a friendly and densely populated continent which would be destroyed by their very strategy of defence. And they handle nuclear weapons as a matter of routine, training them against countries which have become their own nation's most favored trading partners under a policy of detente.

The US Army and Air Force in West Germany have made more than 150 arrests on charges related to drug abuse. The move follows expressions of deep concern by President Carter in Washington to his Generals, as well as discreet, diplomatic signs of anxiety directed to the White House from countries where American troops are based.

Regular use

In the view of Representative Lester Wolff, chairman of the House Select Committee on Narcotics in Washington, the size of the problem in Western Europe is comparable to that involving American troops in Vietnam.

According to the Congressman, a frequent visitor to Europe, initial inquiries suggest that as much as 5% of America's troops in Europe are involved in multiple drug abuse, 9% are hard drug addicts, and 40% are regular marijuana users.

He has viewed the problem with intensifying concern over the years during which drug abuse — which had been considered here as primarily a North American social evil — has come to be acknowledged as a disease equally affecting the young in prosperous Western Europe.

Thus the inquiry may well be widened eventually to embrace other national forces within the alliance.

The US Army recently completed an internal survey focused on its domestic forces concluding that "drug abuse remains a serious personnel problem, particularly among 18- to 25-year-olds, and it merits continued emphasis." It found that 31% of enlisted men and women use marijuana and 7% use heroin.

A spokesman confirmed: "The Army views its drug abuse problem as serious but not of epidemic proportions. The abuse does have some degree of adverse impact on combat readiness but it is difficult, if not impossible, to establish a . . . relationship that can be quantified."

But that survey has been dismissed in Congress as a public relations exercise apparently intended to underplay the actual size of the problem. Glenn English, a member of Mr Wolff's committe, questioned whether information given voluntarily by soldiers jeopardizing their own careers by admitting to an unlawful act, can be accepted as reliable. He also criticized the survey for allowing addicts to determine for statistical purposes whether their own use of drugs could be considered as frequent or as merely occasional.

Mr Wolff and Mr English believe the equivalent of perhaps two divisions of American troops in Europe alone are permanently incapacitated by hard drug addiction. They recently consulted President Carter and said later the White House was about to take action.

Israel facing rise in alcoholism

CHICAGO — Although Jews have been reported to be moderate drinkers, Israel faces a growing problem of alcoholism, especially among young people, according to an Israeli doctor.

Over the last 20 years, Israel has witnessed a steadily increasing growth of alcohol addiction, says Marinel Sagiv, a pathologist at Kaplan Hospital, Rehovot, Israel.

Until the mid-60s, alcoholics were inconspicuous in the general population, he says in the *Archives of Internal Medicine*.

They were mostly middle-aged men or older, and most of them had been born abroad.

Nearly all of them held jobs, had a steady income, and a regular social life.

But in the last 13 years, studies indicate a sharp change in this pattern.

In 1965, the lowest age of alcoholics admitted for the first time to psychiatric wards was 29 years.

In 1973, women were admitted for the first time, along with other alcoholics under the age of 25.

Dr Sagiv notes that most Israeli alcoholics are Oriental Jews, a high proportion coming from Yemen, despite the fact Yemen is a Moslem country where alcoholic beverages are forbidden.

Although Dr Sagiv admits alcoholism is less serious in Israel than elsewhere, it is still a formidable challenge to Israel's health and social systems.

And he has no satisfactory explanation for its occurrence.

NCI studies O-T-C drugs

WASHINGTON — A large number of over-the-counter sleeping aids, nose sprays, and cold medicines should be removed from the United States market because they contain methapyrilene, a potent animal carcinogen, the privately funded Environmental Defense Fund claims.

The organization has requested the Food and Drug Administration (FDA) to order a halt to sales. It cited three studies by the National Cancer Institute (NCI) and the Oak Ridge National Laboratory which, it claims, indict methapyrilene, an antihistamine.

A spokesman for the FDA said the agency is awaiting a final report from the NCI on its testing before making a final decision.

NZ heading for 1984 tranquillizer dependence

WELLINGTON, NZ — This country is heading toward a brave new world of soma drugs.

And New Zealanders are rehearsing for it now, apparently blind to preventive medicine's horror statistics on tranquillizer and alcohol consumption, says D. W. Simpson, a senior clinical psychologist at Auckland University.

Mr Simpson predicts that by the late 1980s a safe, wide-spectrum, non-addictive tranquillizer-sedative will be produced for general use and warns that social workers have until then to develop and demonstrate fruitful casework practices.

"The emergence of widespread competence among social caseworkers could herald a viable alternative to chemicals, for those who would rather deal with their human problems by non-chemical means.

"Otherwise, the pharmaceutical industry will put social case workers out of business, and the whole nation on the pill."

The public is relying traditionally and increasingly on general medical practitioners for help in dealing with human problems, he claimed to social workers recently.

The most recent published analysis of prescribing patterns in general medical practice showed that between 25% and 33% of all patients visiting a doctor leave with a prescription for a psychoactive drug.

Other statistics back Mr Simpson's argument. Health Department surveys show a major increase in prescriptions for psychoactive drugs between 1958 and 1971. Use of powerful hypnotics such as the barbiturates had more than doubled, and this despite the appearance in the 1960s of varied and notable minor tranquillizers such as Librium and Valium, which quickly became prescribed in millions of doses annually.

"Annual Valium consumption alone can now be measured in millions of dollars," says Mr Simpson.

Using Health Department and other data sources, Mr Simpson's projections indicate that on any average day this year more than 10% of the population (4.1 million) will be taking a prescribed tranquillizer, hypnotic, stimulant, or anti-depressant.

He believes the majority of users will be women who are or have been married, with more than one in five being chemically stabilized daily.

Beside such figures, rates for both voluntary and statutory casework agencies pale into insignificance, he says. "And we have not yet considered the self-prescribing medications of choice such as alcohol, tobacco, or marijuana."

New Zealanders continue to spend 3% to 5% of total income on alcohol.

"Clearly, the necessity has arisen for an interdepartmental working party on innovative casework methodology."

No cost drugs: honeymoon over

WELLINGTON, NZ — New Zealand's 40-year-old era of prescribing "free drugs," a basic pillar of the country's world-renowned welfare state system, is rapidly coming to an end.

Minister of Health George Gair has unveiled proposals that in future New Zealanders should pay at least part of the cost of prescription drugs.

The proposals are regarded as just the beginning of a fundamental change of direction for New Zealand's welfare state system, toward one based on "user pay" principles.

In 1978-79, New Zealand's health budget was NZ$984 million and comprised 11.7% of gross government expenditure for a population of 3.1 million. Of the total, in the 78-79 financial year (which ended on March 31), $113 million was spent on prescribing "free drugs."

According to Mr Gair, this was a "staggering" total. He cited evidence that wastage of freely prescribed drugs in New Zealand might be as high as 32%. Perhaps as much as 20% of the country's freely prescribed drugs were in bottles of tablets and tubes of ointment lying unused in bathroom cabinets, he suggested.

"And remember, every single percent of unused drug represents more than a million dollars."

Mr Gair said studies indicated wastage could be reduced by improved counselling prior to discharge. And he believed patients would value their medicine more if they had to make direct contributions to the cost.

New Zealand's system of prescribing medical drugs free of charge was introduced by the first Labour government in the mid-1930s.

However, in recent years, spending in all the social services has increased faster than the growth in the rest of the economy. New Zealand is now spending more as a country than it earns.

Despite the hard economic facts of life, Mr Gair and the government face some strong resistance to the application of "user pay" principles to drug prescriptions.

The Labour Opposition's shadow health minister, Jonathan Hunt, has described Mr Gair's proposals as "appalling" and called on the medical and associated professions to present a strong and united resistance to the government.

The government, however, appears to have little choice but to press ahead with its cost-cutting proposals and allow the economy to catch up, if it ever can.

Mr Gair summed up the blunt truth now facing New Zealanders with the words: "We cannot expect to carry an eight cylinder social services system on a four cylinder economic base."

Rootman off for WHO

OTTAWA — Irving Rootman, chief of program analysis section, Health Promotion Directorate, Health and Welfare Canada, has been granted leave of absence for 12 months from July 1 to undertake a consultancy with the World Health Organization, Geneva.

Dr Rootman will succeed David Hawks as project director for the Community Response to Alcohol-Related Problems project. Dr Hawks, who has been on secondment to WHO for two years, will return to the United Kingdom but will continue to act as a consultant to the project.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Smoking: How To Stop

Subject Heading: Smoking.
Details: 23 minutes, 16mm, color, sound.
Synopsis: After several unsuccessful attempts to stop smoking on her own, a woman joins a group to quit smoking. She is introduced to several techniques to reduce her smoking, such as brushing her teeth without toothpaste in the car instead of smoking, smoking with the other hand etc. At first she follows these techniques faithfully but soon the enthusiasm wears off. At a party, she borrows a cigarette to relax and soon returns to her old smoking habits. However, with new encouragement and support from her family, she rejoins the program and this time she seems to have more success and enjoys her independence from cigarettes.
General Evaluation: Very good (4.8). A highly contemporary, often humorous, informative and technically well produced film with a clear message, this film was considered an effective teaching aid. The A/V Group liked what the film said about smoking and felt it could produce attitudes opposed to smoking. Public broadcast was recommended.
Recommended Use: Likely to benefit audiences of 12 years of age and older. May be particularly useful with groups such as Smoke Enders.

Alcohol Abuse — The Early Warning Signs

Subject Heading: Alcohol and alcoholism overview, professional training
Details: 23 minutes, 16mm, color, sound.
Synopsis: Hosted by Henry Fonda, the film lists 10 of the early warning signs of alcoholism. The 10 signs are dramatically illustrated: increased tolerance, increased desire for alcohol, lack of control over drinking, personality changes, drinking alone, increased dependence on alcohol, neglect of family, loss of pride in job, inability to quit, and physical and emotional deterioration. Fonda urges anyone having any of these signs or knowing someone with these signs to seek help immediately. Some sources for help are also given.
General Evaluation: Very Good (5.1). A highly contemporary, informative, interesting, and realistic film with a clear message, this technically well produced film was deemed an effective teaching aid. The A/V group liked what the film said about alcohol abuse, and felt the film could produce attitudes opposed to alcohol abuse and help in decision-making regarding alcohol use. Public broadcast was recommended.
Recommended Use: Likely to benefit audiences of 12 years of age and older.

Positions Available

Inuvik Alcohol Committee

Program coordinator for alcoholism rehabilitation program in Inuvik. Previous administrative experience in alcoholism field necessary. Salary $20,000 plus housing assistance. Competition open until position filled. Send resume to: Inuvik Alcohol Committee, PO Box 2304, Inuvik, Northwest Territories, X0E 0T0. Telephone: 1-403-979-2726.

Inuvik Alcohol Committee

House manager to administer alcoholism residential rehabilitation centre. Administrative experience in rehabilitation centre, ability to keep inventory controls, and manage staff deployment necessary. Salary $18,000 plus housing assistance. Competition open until position filled. Send resume to: Inuvik Alcohol Committee, PO Box 2304, Inuvik, Northwest Territories, X0E 0T0. Telephone: 1-403-979-2726.

NEW MATERIALS FROM ARF

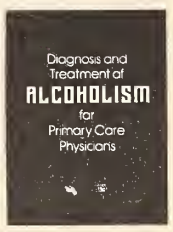
GUIDES

P-151 **DIAGNOSIS AND TREATMENT OF ALCOHOLISM FOR PRIMARY CARE PHYSICIANS** **$1.95**

A 36 page handbook on alcoholism developed for the primary care physician in conjunction with the Ontario Medical Association. A "how-to" guide dealing with identification, diagnosis, short and long-term management in both the medical and psycho-social senses. Invaluable to the medical practitioner.

P-160 **TEN LESSON PLANS FOR GRADES 7 AND 8** **$7.95**
P-161 **TEN LESSON PLANS FOR GRADES 9 AND 10** **$7.95**

The program consists of two sets of 10 lesson plans. Each lesson deals with a separate topic and can be used independently. Developed in conjunction with the Toronto Board of Education. The lesson plans provide the teacher with as much information concerning alcohol and the process of teaching about alcohol as is possible. Includes suggestions for A/V and other materials to enhance the program. The Ontario Ministry of Education has reviewed the lesson plans and found them to fit Ministry guidelines.

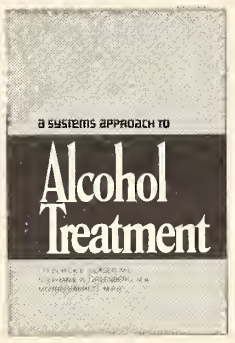


BOOK

A SYSTEMS APPROACH TO ALCOHOL TREATMENT

Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.
$14.95

A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



VIDEO CASSETTE

V-028 **MARIJUANA - THE FACTS** **$95.00**
25 Minutes, Color

Target Audience: Teachers, social workers, health professionals, and general audiences of mid-teens and older. Especially useful in learning or teaching situations.

Content: What is marijuana and what does it look like?

Is it addictive?

Effects compared to alcohol?

Does use lead to harder drugs?

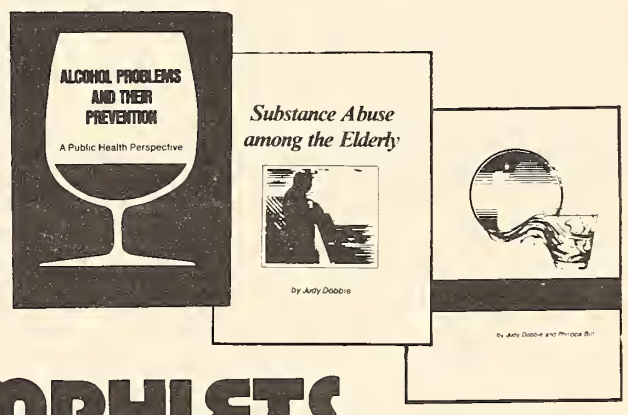
Would use be beneficial for particular medical problems?

PAMPHLETS

P-109 **THE FETAL ALCOHOL SYNDROME** **40¢ each**

P-110 **SUBSTANCE ABUSE AMONG THE ELDERLY** **40¢ each**

P-111 **ALCOHOL PROBLEMS AND THEIR PREVENTION —A PUBLIC HEALTH PERSPECTIVE** **40¢ each**



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INTERNATIONAL COLLABORATION: PROBLEMS AND OPPORTUNITIES

Proceedings of a two-day international seminar marking the designation of the Addiction Research Foundation as a collaborating centre of the World Health Organization.

Areas of discussion include: the epidemiology of alcohol and other drug-related problems, control strategies, and international collaboration in drug abuse programs.

PROCEEDINGS

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New Books

by RON HALL

Alcohol, Other Drugs and Violent Death

. . by Paul W. Haberman and Michael M. Baden

This book presents a detailed analysis of the relationships between substance abuse and unnatural deaths. It demonstrates that alcohol and other drugs of abuse not only contribute significantly to all violent deaths, but are the most common underlying factor in such preventable fatalities. The authors conducted a study of 1,954 cases investigated by the Chief Medical Examiner's Office in New York City during a one-year period. Of those victims, 800 were alcoholics and over 500 were narcotics abusers, including some 200 with both conditions. The underreporting of drinking or drug problems among these cases is discussed, and patterns of substance abuse by descendents and their close relatives are interpreted.

(Oxford University Press, 70 Wynford Drive, Don Mills, Ontario. 1978. 144p. $16.95)

Alcoholism and Treatment

. . . by David J. Armor, J. Michael Polich, and Harriet B. Stambul

Based on the Rand Corporation study, this book reports on data collected from alcoholism treatment centres throughout the United States. It suggests that treatment is, in most cases, successful. The study makes no recommendations about specific treatment goals, and it does not suggest that any alcoholic resume drinking. However, it does question the wide acceptance of abstention as the only method of recovery from alcoholism. Social correlates of alcoholism and problem drinking, patterns of remission, and the effectiveness of treatment are topics which are discussed.

(John Wiley and Sons, Inc, 1 Wiley Drive, Somerset, New Jersey, 08873. 1978. 365p. $16.95)

Other Books

The Nation's Toughest Drug Law: Evaluating The New York Experience — US National Institute of Law Enforcement and Criminal Justice, US Gov't Printing Office, Washington, 1978.

Alcoholism: New Knowledge And New Responses— Edwards, Griffith and Grant, Marcus (Jt eds). University Park Press, London, 1978. Based on papers presented at a conference held Sept 1976. I: Scientific Understand II: Varieties of Harm III: Treatment and Education. Index. 359p. $24.50.

Behavioral Approaches To Alcoholism — Marlatt, G. A. and Nathan, P. E. (Jt eds). Rutgers, New Brunswick, 1978. NIAAA-Rutgers Center of Alcohol Studies Treatment Series No 2. Series editor E. P. Noble. Theory, observations, assessment and treatment. Bibliography, index. VIII, 222p. $6.00.

Turnabout: Help For A New Life — Jean Kirkpatrick. Doubleday, New York, 1978. Personal testimony of founder of Women for Sobriety, Inc. Thirteen statements of Acceptance. $7.32.

Women And Alcohol: A Profile Of Research, Services And Needs — Robinson, T.C. Department of Human Resources, Raleigh, NC, 1978. Printed by WBTV for the first Annual North Carolina Conference on Alcohol and Drug Abuse Among Women, Sept 1978. 1. Reasons for and results of drinking. 2. Services available in North Carolina. 45p.

Psychotropic Drugs: A Guide For The Practitioner — Van Praag, H. M. Brunner/Mazel, New York, 1978. Includes pharmacotherapy of addictions. Special topics: children, aged, emergency cases. Bibliography, index, XXII, 466p. $21.00.

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Coming Events

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Canada

10th International Congress For Suicide Prevention And Crisis Intervention — June 17-20, Ottawa, Ontario. Information: Secretariat, IASP Congress '79, 700-71 Bank St, Ottawa, Ont, K1P 5N2.

70th Annual Conference Of The Canadian Public Health Association — June 18-22, Winnipeg, Manitoba. Information: Mr G. H. Dafoe, executive director, CPHA, 1335 Carling, Suite 210, Ottawa, Ontario, K1A 8N8.

Summer School On Alcohol And Drugs — August 20-24, Calgary, Alberta. Information: Ms A. Steiestol, Conference Secretary, Summer School on Alcohol and Drugs, 812-16 Avenue SW, 2nd floor, Calgary, Alberta, T2R 0T2.

Input '79 — 3rd Biennial Canadian Conference On Occupational Alcoholism And Drug Abuse — Sept 23-26, Ottawa, Ontario. Information: Input '79 headquarters, Conference and Seminar Services, Humber College of Applied Arts and Technology, Box 1900, Rexdale, Ont, M9W 5L7.

Canada Safety Council's 11th Annual Safety Conference — Sept 30-Oct 3, Quebec City. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario, K1G 3V4.

Detox Training Program — Oct 15-19, Nov 12-19, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

United States

14th Meeting — Association Of Halfway House Alcoholism Programs — June 3-7, Lincoln, Nebraska. Information: AHHAP, 786 East 7th St, St Paul, Minnesota, 55106.

The 41st Annual Scientific Meeting Of The Committee On Problems Of Drug Dependence, Inc — June 4-6, Philadelphia, Pennsylvania. Information: Dr Leo E. Hollister, Veterans Administration Hospital, 3801 Miranda Ave, Palo Alto, California, 94303.

6th Annual Puerto Rican Substance Abuse Conference — June 5-8, Santurce, Puerto Rico. Information: '79 Conference, National Association of Puerto Rican Drug Abuse Programs, 1766 Church St NW, Washington, DC, 20036.

Ohio Drug Studies Institute 1979 — June 11-15, Columbus, Ohio. Information: ODSI Training, Division of Mental Health, 13th floor, Room 1346, 30 East Broad St, Columbus Ohio, 43215.

Issues Of Sexuality In Alcoholism Counseling — June 15-16, Center City, Minnesota. Information: Marilyn Brissett, Hazelden Foundation, Box 11, Center City, Mn, 55012.

University Of Utah School On Alcoholism And Other Drug Dependencies — June 17-22, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, Utah, 84110.

Southern Oregon Institute Of Alcohol Studies — June 17-22, Ashland, Oregon. Information: Ruthanne Lidman, coordinator, SOIAS, 3355 View Drive South, Salem, Or, 97302.

Pharmacology For The Nurse — June 28-29, Center City, Minnesota. Information: Marilyn Brissett, Hazelden Foundation, Box 11, Center City, Mn, 55012.

21st Annual International School Of Alcohol Studies — July 15-20, Grand Forks, North Dakota. Information: F. Wittmann, conference coordinator, University of North Dakota, Continuing Education, Box 8277, University Station, Grand Forks, ND, 58202.

Annual Summer Institute Of Drug Dependence — July 29-Aug 3, Colorado Springs, Colorado. Information: Summer Institute of Drug Dependence, PO Box 2172, Colorado Springs, Co, 80901.

4th Annual Conference On Employee Assistance Programs In Higher Education — Aug 7-10, Newport, Rhode Island. Information: Employee Assistance Program, University of Missouri-Columbia, 215 Columbia Professional Building, 909 University Avenue, Columbia, Missouri, 65201.

6th National Drug Abuse Conference — Aug 26-30, New Orleans, Louisiana. Information: NDAC '79, 115 S Chestnut St, Lafayette, Louisiana, 70501.

30th Annual Meeting Of The Alcohol And Drug Problems Association Of North America (ADPA) — Aug 26-30, Washington, DC. Information: Driscoll and Associates, 1925 North Lynn St, Suite 1001, Arlington, Virginia.

4th International Conference Of Therapeutic Communities — Sept 16-21, New York City. Information: Charles Devlin, coordinator, Daytop Village, Inc, 54 West 40th St, New York, NY, 10018.

Abroad

International Conference On Animal Models In Alcohol Research — June 4-7, Helsinki, Finland. Information: John David Sinclair, Research Laboratories of the State Alcohol Monopoly (ALKO), Box 350, SF-00101, Helsinki 10, Finland.

The 6th World Congress Of Acupuncture — June 17-22, Paris, France. Information: Pierre Bidault de Villiers, Service Presse "Mondial", 3 Ruse de la Grande Truanderie, 75001 Paris, France.

4th World Conference On Smoking And Health — June 18-21, Stockholm, Sweden. Information: 4th World Conference on Smoking and Health, c/o RESO Congress Service, S-105 24, Stockholm, Sweden.

25th International Institute On The Prevention And Treatment Of Alcoholism — June 18-22, Tours, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

The 1st International Conference On First Aid At The Scene Of An Accident — June 19-23, Oslo, Norway. Information: The Norwegian Automobile Association, NAF, PO Box 494, N-Oslo 1, Norway.

3rd World Congress Of The International Commission For The Prevention Of Alcoholism And Drug Dependency — Aug 26-31, Acapulco, Mexico. Information: ICAP executive director, 6830 Laurel St, NW, Washington, DC, 20012.

10th International Conference On Health Edueation — Sept 2-7, London, England. Information: The Conference Centre, 43 Charles St, Mayfair, London, W1X 7PB, England.

Rise in Islamic fervor revives bans on alcohol, drugs

Koran a mighty sword against intoxicants

The Islamic revival now gripping wide areas of the Middle East has brought in its wake strict bans on alcohol and drugs. Drinking and drug-taking had previously been tolerated as little more than bad habits. Now, the Koran rather than secular laws is dictating many people's day-to-day life and both alcohol and drugs have been condemned as being contrary to the ways of Islam. Trade has been driven underground.

Most fervent in the crusade against the evils of drink and drugs has been the deeply religious Pakistani leader General Zia ul-Haq. He took control of Pakistan, after the downfall of Premier Ali Bhutto, determined to initiate *Nizam-e-Mustafa* — enforcement of the Islamic way of life. Islam had to be restored to produce a more content and just society, he said. The criminal and civil laws were duly changed to conform with the Sharia — the Islamic code of justice based primarily on the Koran.

The Koran forbade the drinking of wine because it made people lose control of their minds. But General Zia went further. He passed a law prohibiting the importing, buying, or selling of intoxicants. Offenders are liable to five years imprisonment and 30 lashes. Punishment for drinking is 80 strokes, as laid down in the Sharia. Among intoxicants, General Zia included opium, marijuana, and cocaine — all fairly common drugs to many Pakistanis.

The ban on opium was particularly savage. Eating it has become a national practice and before General Zia took' over, had been considered to be permitted by Islam. Under the ban, all government 'vends' — specially licensed outlets where opium had been sold legally — were immediately closed down. The shutters also went down on special government dispensaries and no special rehabilitation schemes were arranged.

Soon many of Pakistan's estimated 120,000 opium addicts were presenting themselves at hospitals with 'cold turkey' withdrawal symptoms — diarrhea, vomiting, sleeplessness, and feelings of fear. The Central Government hospital in Rawalpindi reported admitting 23 severe cases of opium withdrawal within two days of the prohibition order. Another 27 were being treated as out-patients. The official death toll of addicts rose to 40 within a few weeks although unofficially it was believed to be far higher.

Pakistani narcotics experts are reported to have tried to persuade the government to change its mind, insisting the best way to combat the country's drug problem was through the controlled sale and cultivation of opium. This would at least allow authorities to keep watch on trade.

But General Zia took little notice. Ironically, at the time of the prohibition order, Sahibzada Raouf Ali, head of the Pakistani Narcotics Control Board, was elected vice-chairman of the United Nations Commission on Narcotic Drugs.

Faced by numerous deaths among addicts, the government did begin to show some compassion. A limited number of opium tablets was supplied to district excise departments and to doctors so some of the most serious cases could be weaned off the drug slowly. Many addicts, however, were offered merely analgesics and tranquillizers at hospitals.

With the underground market price of opium soaring sky-high, illegal dealers began making huge profits. A tribal area around the town of Landi Kotal on the Pakistani-Afghan border, where the government carried little authority, had traditionally supplemented the limited official supplies of the drug: now it became virtually the only source of opium.

Pakistan's ul-Haq: Going one beter on the Koran

Pakistan was estimated to have been consuming more than 100 tons of opium annually, only a small proportion of which was legally cultivated. This year's poppy crop is thought to be a bumper one — up to 15% higher than the last estimated annual yield of 270 tons. With the domestic market going through an officially enforced slump, there is mounting concern among international narcotics authorities that the enormous surplus crop will find its way to Western Europe and the United States.

The Pakistani government has been almost as ruthless with drinkers as drug users. Within days of the prohibition order, people were hauled before the police for being under the influence of alcohol and were publicly flogged.

Non-Muslims caught drinking in public places now risk three years hard labor and 30 lashes although they are permitted to drink in private. Special liquor stores have been opened in major cities, from which alcohol can be bought two hours each day on presentation of an official permit. These, however, have been refused to anyone of Muslim descent.

For Pakistanis the liquor trade has gone underground. An active black market in whisky has begun to emerge. But breweries, set up under the British Raj to cater for colonials, have closed down. One large brewery in Karachi has been trying hastily to work out a recipe for non-alcoholic beer.

In neighboring Iran, Ayatollah Khomeini, leader of the revolution which toppled the Shah, has also ordered a return to the concepts of the Koran. The subsequent drive against alcohol, however, has not been as uniformly harsh as in Pakistan. Perhaps this is an indication of the less rigorous approach of the predominant Shia sect in Iran, than of more orthodoz Sunni Muslims like General Zia. There have been no legal decrees banning drink in Iran, merely declarations from the Ayatollah and other leaders.

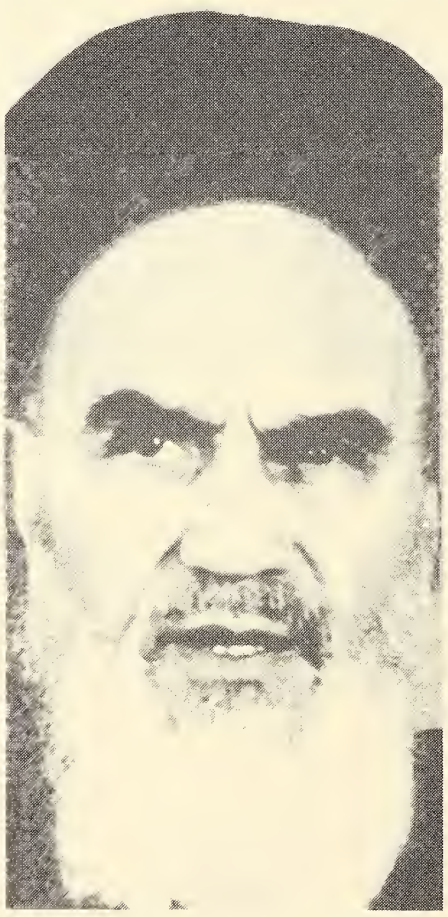
Enforcement has been left to the whims of the revolutionary committees which hold most power in the country. In Kerman, a city in the south east, the committee has been severe. Two young men were given 80 lashes for drinking alcohol and, true to fundamentalist Islamic tradition, the punishment was administered before a huge crowd of men and women in a local mosque.

In the capital, Tehran, the attitude of the committee has not been quite so stern. The city's night clubs, havens for late-night drinkers, have closed down and the small street bars where a large glass of local beer could be bought for $2 have shut. More than a dozen large plants bottling or producing beer, vodka, wine, and other alcoholic drinks, have stopped production.

Drinking still goes on, though surreptitiously. *Sharab*, the strong, fruity Iranian wine, is served in restaurants in tea pots. Whiskey costs $70 a bottle on the black market — about three times more than in pre-revolutionary days.

There are already some signs of a possible relaxation on restrictions by the authorities. Ayatollah Khomeini is reported to have considered allowing a Tehran brewery to reopen to save jobs although the cabinet turned down a plan to set up one plant to make alcoholic drinks for non-Muslims. Still, the leadership appears to be considering allowing alcohol manufacture — if on a limited scale.

Wine-making, in particular, may be more difficult to stamp out. In places like Shiraz, Qazvin, and Rezaiyeh, wine growing has traditionally been a source of income to local farmers. The district around Lake Rezaiyeh in West Azerbaijan, near the Turkish border, has numerous vineyards. Azerbaijan, with a high proportion of Sunni Turkish-speaking people, is demanding greater autonomy and may not take kindly to the Shia central government's telling it to shut down one of its more profitable industries.



Iran's Khomeini: Enforcement varies in revolutionary committees

So far, the government has resisted any temptation to unleash an anti-drug drive in the name of Islam — although the country has an estimated 400,000 opium smokers and around 50,000 heroin users. One reason is that the opium trade was pushed underground around 10 years ago when the Shah closed down official opium vends. With the present disorganized state of the Iranian security forces, the authorities hardly have the capacity for a crackdown on an undercover drug market. At the same time, there is little evidence of any move against rehabilitation and treatment schemes established under the Shah. These have been dealing with about a third of the country's addicts.

The Islamic revival is also sweeping through Turkey, the Levant, and North Africa, although with not nearly such dramatic effect as in Iran and Pakistan. Even the authoritarian socialist government in Iraq, which has not shown much respect for religion, has been forced to bow to the new trend. It has banned gambling and closed down a popular race course in Baghdad. So far, the country's small but thriving beer industry has been left untouched.

Egypt's Sadat: May relax anti-alcohol restrictions

In Egypt — the largest Arab country — President Anwar Sadat has tried to keep pace with the Islamic resurgence. He has restricted sales of alcohol and the Peoples Assembly, dominated by Sadat nominees, has been debating whether to close down bars, nightclubs, and gambling casinos along Cairo's Pyramid Road.

President Sadat has tended to give priority, however, to political expediency rather than religious conviction. The clamp-down on alcohol resulted from pressure from Saudi Arabia when that country was Egypt's main source of foreign aid. The Egypt-Israel treaty has left the country isolated in the Arab world, forcing it to look to the West instead. President Sadat now may well relax the anti-alcohol restrictions, particularly if it encourages Western tourism.

Meanwhile, Saudi Arabia itself and its neighboring sheikhdoms in the Arabian Peninsula have given some indication of the direction countries imposing new drink bans are likely to take. Islam was born in this region more than 1,300 years ago and over the last 200 years had tended to be more strictly observed here than elsewhere.

Nevertheless, these countries have shown how difficult it is to eradicate drinking completely. In Saudi Arabia, a liquor blackmarket is flourishing, giving fat profits to underground merchants. European and American expatriate workers have been making around $1,500 a week in their spare time distilling illegal alcohol. But the big money is made by Saudis trading in whisky costing up to $100 a bottle. Truckloads of liquor find their way into the country from Lebanon and Syria. Alcoholism is beginning to become a serious problem among rich Saudis.

All this should be a warning to the fundamentalists now in control in Iran and Pakistan. But will it be heeded?

— Report by Sean Milmo

THE BACK PAGE

Alert on tobacco/ hashish mixture

By Harvey McConnell

PHILADELPHIA — Bronchial biopsies read independently by three leading United States pathologists have confirmed severe abnormalities in the respiratory systems of a group of American soldiers who smoked both hashish and cigarettes.

"Some of our biopsies are almost cancer, and these were taken from young men who were an average 20-years-old at the time," Forest Tennant told **The Journal**. The study was done between 1971 and 1974 while Dr Tenant, of West Covinna, California, was a US Army medical officer stationed in West Germany.

He presented the report, which has been purposely held back until now, at the annual scientific meeting here of the Committee on Problems of Drug Dependence.

Dr Tennant said that because of the size of the study it is not possible to say hashish smoking alone is more damaging to the lungs than cigarette smoking alone. However, the combination of hashish and cigarette smoking prodnces dramatic changes.

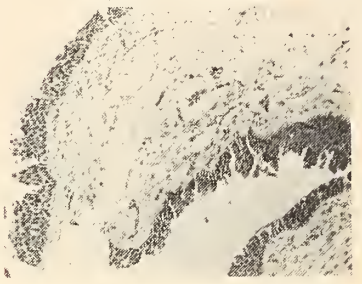
Dr Tennant's co-investigators are Dr Roderick Guerry, a pathologist, and Dr Robert Henderson, an ear, nose, and throat specialist. On their return to the US they decided to have the biopsies evaluated "by scientists who would be as unbiased as possible and who were independent of our study," Dr Tennant explained.

The biopsies were read by Dr Oscar Auerbach, Veteran's Administration Hospital, East Orange, New Jersey, who is renowned for his work linking cigarette smoking and lung cancer; Dr. Walter Coulson, University of California at Los Angeles; and Dr William Johnston, Duke University Medical Center, Durham, North Carolina.

Dr Tennant: "Their reaction when they learned the age of these young men was dramatic. There are no questions about the abnormalities they found."

Dr Tennant said one reason for

(See — Lung — page 2)



This bronchial biopsy, which shows respiratory abnormalities, was taken from a 20-year-old smoker of hashish and cigarettes.

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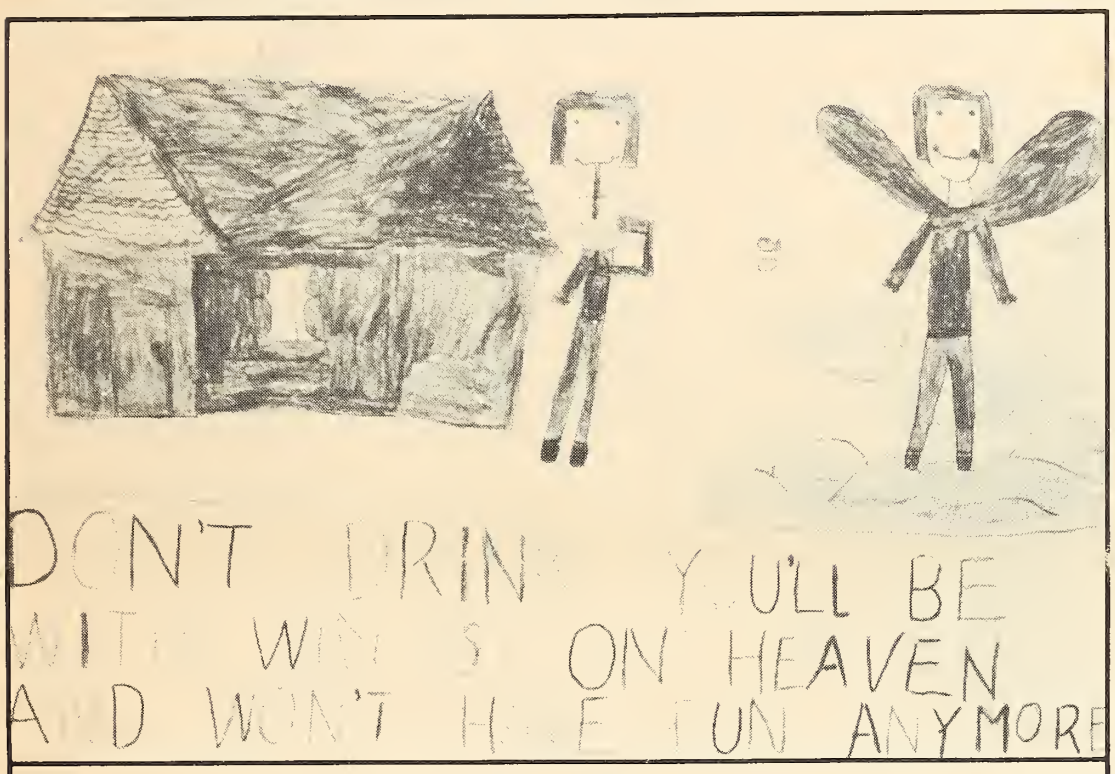


Announcing the winners...

... of the Addiction Research Foundation's Poster Festival — The Back Page. Artist of this winning poster is kindergarten student James Cho of Caramat, Ont.

Feds to tighten drug file controls

By Jeff Carruthers

OTTAWA — Officials with the federal health protection branch plan to meet with the federal Privacy Commissioner Inger Hansen to discuss "reasonable" ways of tightening controls on who can receive information from health department drug files.

The meeting follows an article in The Journal (June) suggesting highly personal information from the health department's controversial illicit drug user data bank was being mailed to individuals without requiring positive proof of identity.

Alex Morrison, assistant deputy minister in charge of the branch, stressed the department is as concerned about being overly restrictive in responding to questions from individuals to see what's in their personal files, as it is about violating personal privacy by having the information fall into unauthorized hands.

He said, for example, that he would not consider requiring finger-prints to be provided as proof of identity, as is required by the RCMP for people requesting copies of their criminal records.

Nor would it seem correct to require individuals to pick up copies of their drug files from local police stations in areas remote from federal health department branch offices.

Such requirements could end up infringing on the essential doctrine of "access" to personal files held by the government, and could conceivably infringe in other ways on personal privacy.

However, Mr Morrison agreed the current health department policy of requiring only date and place of birth, and current address as proof of identity seems

(See — SINs — page 2)

New health minister will keep pot promises

By Jeff Carruthers

OTTAWA — Decriminalizing cannabis use, and taking a more aggressive "lifestyle" advertising approach against alcohol and other drug abuse are two of the personal priorities of Canada's new minister of health and welfare.

David Crombie, the former Toronto mayor, says decriminalizing cannabis use is one of the Conservative election promises the new government intends to keep.

In an interview with **The Journal**, Mr Crombie explained the Party policy enunciated during the election campaign will receive "top priority" during the next session of Parliament.

However, he admitted he hasn't had time to establish his own legislative priorities, and neither has the Conservative minority government that came to power May 22.

Since Parliament will not sit until the fall, this means that even with priority, legislation to decriminalize cannabis could not become law until year end at the earliest.

Mr Crombie stressed the Conservative approach would be to diminish the "criminal" aspects of cannabis use, "not condone it."

While this would mean people would not forfeit their ability to be bonded, for example, since simple cannabis crimes would not carry with them a criminal record, the import, sale, and trafficking of the drug would still be illegal.

The health minister said the thrust of decriminalization is to "ensure that great hosts of young people are not stained for life" for their indiscretions.

On lifestyle advertising, Mr Crombie said a more aggressive and creative tack should be taken by Ottawa.

The minister said he doesn't believe trying to restrict the way private advertisers of alcohol and cigarettes, for example, depict their products is that effective. The previous government had been trying to discourage beer advertisers, for example, from portraying beer drinking as a highly sociable activity, or from associating smoking and drinking with athletes and other status symbols.

Mr Crombie said if those kinds of advertisements are really going to sell beer, the companies will resist attempts to eliminate or control them. Instead he foresees a much more aggressive government campaign of alternative lifestyle advertising designed to counter the impact of the industry ads.

"We're going to have to hire some talented people" to prepare effective ads, he said.

He also suggested there should be an emphasis on reaching young people in schools — something that would require cooperation from the provinces, which control education.

All of this said, Mr Crombie still believes it's worth having tough regulations aimed at controlling alcohol consumption and the use of illicit drugs.

It is telling that during the days of intensive briefing on pressing issues by department officials the week before the Crombie interview, very little time was devoted to briefing the minister on illicit drug use problems.

This suggests illicit drug use is not viewed as a major problem at this time, and that the department officials hope to clear away the more pressing problems during the summer months, and then begin tackling broader policy issues.

Canada's new Health Minister David Crombie plans to decriminalize marijuana but stiffen regulations against use of illicit drugs.

INSIDE . . . . . Page 2

Supreme Court not taking 'light' beers lightly

and

Drug abuse treatment big business: Chisholm

Dark days ahead for 'light' beers

OTTAWA — The right of the federal government to restrict the amount of alcohol contained in so-called "light" low-calorie beers to a maximum of 2.5% alcohol by volume is being put to the test before the Supreme Court of Canada.

The outcome of the case involving Labatt's "Special Lite" (with about 4% alcohol) will have far-reaching effects for the beer industry, and for federal regulating in the whole food and drug area.

If John Labatt Limited should lose its case, another heavily advertised product, Molson's "Light" (with 4.5% alcohol) would either have to be reformulated or face almost immediate legal action under federal labelling regulations.

If the federal government should lose, then the federal rights to control by statute and by regulation in the food and drug areas could be seriously undermined, perhaps even destroyed.

Both sides have each won a case in the lower courts, with the federal government winning the federal Court of Appeal, one step below the Supreme Court.

The beer companies maintain they have the right to sell a beer with slightly less alcohol (the maximum allowed for regular beer is 5.5%), and call it "light" or "lite," as long as the consumer is informed of the true alcohol content on the label and in advertising.

The federal government, in defining its regulations restricting the maximum alcohol content for beers labelled "light" is 2.5% alcohol by volume.

As part of the court challenge, the Labatt company is claiming the Food And Drug Act which Ottawa uses to control beers is "ultra vires" Parliament, that is beyond the jurisdiction of the federal Parliament. The company further maintains the right of the government to establish standards for beer by Order in Council (Cabinet order) is also ultra vires.

Even though the federal government has managed to survive all such challenges of its food and drug legislation and regulations to date, federal officials are concerned about the broad impact if they should lose this particular case.

The verbal evidence was to be presented before the Supreme Court on June 27, and a court decision is expected later in the summer.

'Wipe out drug profits': Chisholm

KING OF PRUSSIA, PA — America is still dealing with the effects of drug abuse and not the causes, despite an army of trained professionals to handle its myriad aspects.

Congresswoman Shirley Chisholm believes "drug abuse treatment is a big business for both government and, increasingly, private industry.

"There are a lot of people involved, and a lot of money is being spent, and it is becoming increasingly clear to me, and other members of Congress, that the fight against drug usage no longer is happening constantly in the community. Rather, the biggest effects are within, and between, competing organizations in government at all levels.

In addition, Congresswoman Chisholm told the 12th annual Eagleville Conference here, the theoriticians and academicians who plan most programs lack field experience, and do not receive any input from people in the field as they sit in Washington and put together proposals.

On the community level too, many young people are being put in charge of programs who are ill-equipped to deal with the people they are supposed to help.

Congresswoman Chisholm told The Journal **that she no longer accepts the automatic refunding of institutions and programs, "unless we take a good look and assess them and evaluate what is being done."**

Congresswoman Chisholm said: "It is the tremendous profits to be made from the sale of illegal drugs that present the greatest problem. Preventive measures and education and rescue operations for the addict will not suffice if society is not willing to wipe out the huge profits, either by a determined attack on corruption, or by a change from prohibition to regulations and legal control."

Lung cancer for hashish users?

(from page 1)

delay in presenting the study was the normal lag in collecting data and writing it up.

"But, quite candidly, there is another reason why we have not presented our report until now. There has been a time when to say anything negative about cannabis has been tantamount to producing personal attacks, condemnations, and other crazy reactions.

"Now, the climate is a little different, and you have some cannabis users who recognize the drug may cause harm."

In the study, 30 chronic hashish smokers with respiratory symptoms, and six controls who were not hashish smokers, were evaluated by history, physical examination, bronchoscopy, and brochial biopsy.

All of the hashish smokers had sought medical assistance for one or more respiratory symptoms: cough, excess sputum production, chest pain, hemoptysis, or dyspnea. They ranged in age from 17- to 22-years-old.

All of the hashish smokers reported a consumption of between 25 and 150 grams a month, and had smoked from three months to two years. Twenty-three of the hashish smokers also smoked an average of one pack of cigarettes a day.

Three of the controls had smoked a mean of 1.6 packs of cigarettes a day for 10 to 12 years. The three other controls were non smokers.

Biopsy showed that every one of the 23 men who smoked both hashish and cigarettes had one or more histopathologic abnormalities of basal cell hyperplasia, atypical cells, or squamous cell metaplasia.

Similar histopathic lesions were found in two of the seven hashish users who did not smoke cigarettes, and one of the three cigarette only smokers. No changes were found in the non-smokers.

Dr Tennant said the abnormal histopathologic lesions found in the 23 men who smoked both hashish and cigarettes "are identical to those frequently associated with later development of emphysema and carcinoma of the lung." Squamous metaplasia, the most serious of the lesions, were found in 21 of the 23 men.

Dr Tennant said the hashish the men smoked was of a potency not then seen generally in North America. "However, we are now seeing much higher grades of cannabis coming into this country, and containing a much higher percentage of THC, and I anticipate that a lot of the things we saw in Europe are going to happen here.

"I am sure that within three to 10 years we are going to see cancer of the lung in people who are chronic cannabis users."

He added that a number of animals studies have shown that marijuana smoke causes similar lung lesions.

The changes found in the young soldiers who smoked hashish and cigarettes "are similar to those it takes a cigarette smokers about 20 years to reach.

"What we are talking about here are people who are chronic cannabis users, and if they are cigarette smokers as well, they really need to evaluate what they are taking into their lungs."

Ironically, because much of the cannabis now arriving in North America is in the 12% to 15% THC range, Dr Tennant thinks he may be inclined to make marijuana use legal.

He added: "If you make it legal then you could limit sales to marijuana with a 1% THC content, and this may be the only way to protect the public health."

SINs won't do for ID

(from page 1)

inadequate since this information is widely available to other people or groups that might want to obtain personal files.

When asked whether copies of drug files were ever sent by registered mail, the department said this wasn't being done, in part because officials were not sure this was an effective way of ensuring the information didn't fall into the wrong hands.

Mr Morrison said the department can't and won't use social insurance numbers (SIN) to verify identity. Such numbers are not now included in the drug files, and would not be included because of the fear that use of SIN numbers could increase the abuse of the many government files now being held in Ottawa.

The only other common piece of information in the drug files is the place of conviction, and this only applies in cases where individuals have actually been convicted. Even this is not useful since many individuals don't actually know in which particular borough they were convicted.

The drug files question covers several hundred thousand Canadians who are known or suspected users of illicit drugs. The vast majority, 191,581 at last count, cover known or suspected users of cannabis.

Under the Human Rights Act, every Canadian has the right to receive a copy of their files from designated federal data banks to ensure the information contained is accurate, and to request corrections of mistakes.

Alice lands in (liquor board of) Wonderland

By Wayne Howell

What strange adventures Alice had experienced since she followed the White Rabbit down a hole: she'd met a Mock Turtle, a carpenter who talked to a Walrus, and a Cheshire Cat. So it did not surprise her when she came upon a most curious cafe, set in the woods. Seated at one of the tables, and looking very disconsolate, were a Hatter and a March Hare. Between them lay a snoring dormouse, his head on the table.

"Oh please come in and eat," cried the Hare and the Hatter when they saw Alice approaching. But Alice was not hungry.

"I'll just have a drink, if you don't mind," she said politely. The Hatter looked as if he were about to cry.

"Oh please eat," he implored, pointing to a table piled high with peanut butter sandwiches — the last thing in the world the thirsty girl wanted.

"No thank you," said Alice.

"But you've got to eat, you've got to help us," pleaded the March Hare, who looked even more depressed than the crying Hatter. "You see, the LLBW — that's the Liquor License Board of Wonderland — has decreed that 50% of our revenues must come from the sale of food. But customers like this dormouse here have tilted the balance to the liquid side: the LLBW is extremely annoyed and threatens to close us down." The Hare gave the sleeping dormouse a kick but the furry creature just burped and continued snoring. Alice looked bewildered.

"You see," said the Hatter, "there was a time when the LLBW said you *had to eat* in a restaurant or you *couldn't drink at all*."

"That's not true," mumbled the dormouse who had finally responded to the March Hare's kick. "What you had to do was order the food and pay for it but you didn't *have to eat it*; my goodness, I've seen these chaps sell the same plate of crackers and cheese all day long."

"But that was yesterday," said the Hatter, giving him another kick, "and today is today, and today the LLBW says you don't *have to eat*, and we can't *make you eat*, but if you *don't eat enough*, we're out of luck — they close us down." Both the Hatter and the Hare were weeping copious tears by this time and Alice began to feel sorry for them. Not much that they had said made sense to her (would it to anyone?), but she did want to help them out.

"Perhaps I shall have one peanut butter sandwich," she said.

"One peanut butter sandwich coming right up," said the Hatter.

"That will be two guineas, please," said the March Hare. Alice was shocked.

"Shame on you asking two guineas for a peanut butter sandwich," she exclaimed.

"It was his idea," said the Hatter sheepishly, pointing at the March Hare.

"But *everyone does it*," said the Hare. "If you've got a dining lounge license and your food/drink profit ratio isn't coming out to the LLBW's satisfaction, you simply raise the price of the food you sell — *that's the way it's done in Wonderland*."

"Why couldn't you just lower the price of the drinks instead," said Alice.

"Because the LCBW is constantly raising the wholesale price of drinks and this has the effect of constantly increasing our drink profits so the only way we can maintain our food/drink balance is to increase the price of food, since we have no room for rooms."

"What have rooms got to do with all this?" cried Alice in frustration. Her outburst woke the sleeping dormouse who looked at her with bleary eyes and began to sing in a sad little voice.

Rooms, rooms, beautiful rooms,
If they had rooms, they'be be tycoons . . .

"What's he singing about?" said Alice, who was becoming more and more confused.

"If instead of owning a pleasant cafe we owned a hotel — even a grungy, rundown hotel with only two or three rooms to let out to winos and hookers — then we could serve you *all you wanted to drink all day long and never have to sell you a thing to eat*," explaind the Hatter. Alice was still trying to make sense of this remark when the dormouse stirred himself for the third time: he rose unsteadily to his feet, bowed to Alice, and wandered out into the street.

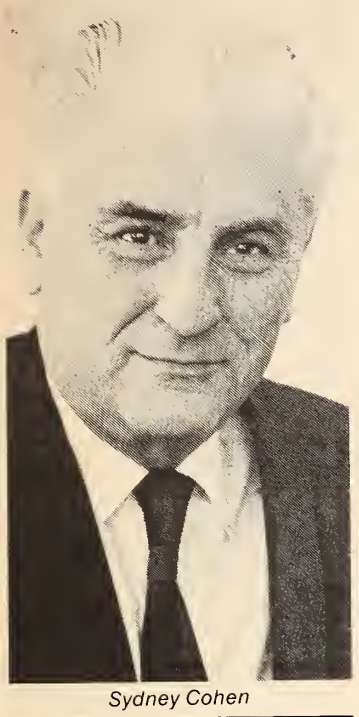
"Where is he off to?" she asked.

"Oh him, he's off to the LCBW retail store. You can go to the LCBW store and buy *all the drink you want* and they don't make you eat so much as a soda cracker. You can spend 90% of your income on drink at the LCBW retail store and only 10% of your income on food: neither the LLBW nor the LCBW cares about that," the Hatter explained.

But it made no sense to Alice: more and more she began to suspect that this was all a silly dream.

It was, of course.

Now drug warnings 'decrees', not guides



Sydney Cohen

PHILADELPHIA — Many states have now gone beyond federal regulations and defined the drug package insert indications for use as the basis for medical practice, believes Sydney Cohen, professor of psychiatry, University of California, Los Angeles.

This means if a doctor prescribes a stimulant "for an atypical depression unresponsive to conventional therapies" the results can be "investigations, administrative hearings, and a variety of penalties," Dr Cohen told the annual scientific meeting here of The Committee on Problems of Drug Dependence.

The object is to deter diversion of drugs open to abuse into non medical channels, but these efforts have culminated "in nit-picking efforts" to force medical practice into a rigid mould.

Dr Cohen said if a doctor appears before an administrative judge "who is not a physician, and who does not understand the great variability of human response to psychotherapeutic drugs, things can go badly for the clinician who tries to do as much as he can for his patient.

"Unfortunately, judges do not assume responsibility for seriously ill patients."

The package insert is only an agreement between a pharmaceutical company and the Food and Drug Administration "and I know of no legal status it has involving doctors," Dr Cohen continued. "Nevertheless, it is being used, not as a guide, but as some absolute decree that must not be transgressed."

"Unfortunately, there are a few patients whose needs do not happen to conform to the pronouncements of the package insert."

Dr Cohen said if the United States has become a drug-oriented society "it is because, in part, our citizens have come to expect rapid relief from conflict, unease, and other forms of real or imagined psychophysical distress. This is true especially, but not exclusively, in young people who seek chemical solutions for whatever shyness, boredom, or tensions of everyday life they may encounter.

"It is not better, but easier, living through chemicals."

Dr Chester Cavalitto, adjunct professor, school of pharmacy, University of North Carolina, told the conference there are limits on how far the government can go in protecting people from themselves when it comes to drug abuse.

America has a large, active and imaginative drug abuse subculture.

He said stricter controls on the prescribing of barbiturates has reduced the number of suicides using the drug, but this has had no effect at all on the overall rate of suicide.

Pharmaceutical companies face a major dilemma when they consider developing a drug which may have abuse potential. If it may probably be classified "this may become the economic straw that broke the development camel's back."

Cirrhosis program falters

By Betty Lou Lee

OTTAWA — Faced with increased prevalance of cirrhosis and a significant mortality rate, the Victoria BC General Hospital set out to improve its quality of care for this disease.

Although a staff education program stressed better history-taking, physical examination, investigation, and treatment, the death rate after the program was 32%. Before, it was 23%.

And although one of the aims of the program was to improve the rate of out-patient alcohol counselling after discharge, that rate fell from 13% to 11%.

About 65% of patients improved both before and after the program. The average length of stay in hospital increased from 17 to 19.7 days.

One unexpected, and still unexplained, finding from the study of cirrhotic patients in 1975 and 1978 was a high number of elderly women. Females over 60 accounted for six of the 26 patients in a quarter of 1975, and 11 of 41 patients in a quarter of 1978.

The study was conducted by Dr Alan G. Clews and Laurie A. King, chief medical record librarian. The results were presented by Dr John Carroll at the 25th anniversary meeting here of the College of Family Physicians of Canada.

After studying the case records of the 1975 patients, criteria for care and evaluation were drawn up.

In history taking, all patients' records were expected to record alcohol usage, alcohol information from a friend or relative, recent anesthetic, recent diet, and previous gastro-intestinal bleeding or jaundice.

The actual standard for some of these items in 1975, with 1978 in brackets, included: alcohol use, 91.7% (87.8%); friend information, 13% (36%); GI bleed, 23% (39%) and jaundice, 30.8% (46.3%).

Among expected recorded items from the physical examination, mental status or mood showed the biggest change, up from 35% to 63%. Rectal examinations dropped from 73% to 61%.

In-hospital alcohol counselling, for patients where it would be applicable, remained around 30% in both years. A high protein diet was expected as part of the treatment. In 1975 it was prescribed for 8%, and for 39% in 1978. Multivitamins, also expected, were prescribed for 27% in the earlier study, 51% in the later one.

Expected investigations included chest x-ray, hemoglobin, Australian antigen, blood glucose, alkaline phosphatase, serum bilirubin, electrolytes, serum protein, prothrombin time, SGOT (for liver damage), and venereal disease. With the exception of VD, a high percentage of patients had these tests in both study periods.

Confrontation therapy OK: Carroll

By Harvey McConnell

KING OF PRUSSIA, PA — Confrontation therapy for drug abusers is often a source of ethical debate, but if done responsibly there is no conflict, in the opinion of Jerome Carroll, PhD, Eagleville Hospital and Rehabilitation Center.

Dr Carroll told the annual Eagleville Conference here that while some worry about possible abuse or unethical practices in confrontation sessions, in truth most all therapeutic treatments involve some degree of confrontation, and are thus subject to abuse.

Already, new laws regarding civil liberties have caused many counsellors to become extremely cautious in using confrontation because of the fears of a malpractice suit. In addition, many traditionally trained professionals often do not like the technique.

Dr Carroll said some of the disquiet is due to serious abuses of confrontation by some therapists. Most often, this is a result of poor training.

In addition, many people in the substance abuse field have never come to grips with their own feelings. "Observing the 'white heat' of a confrontation session, especially when it centres on a problem they have left buried as 'unfinished business,' can truly be an unsettling experience."

Many of the detractors of confrontation in substance abuse rehabilitation have only an abstract understanding of what it is like to do therapy with an addicted person.

Dr Carroll: "They have never had to deal with that near impregnable wall of resistance which most substance abusers will present in therapy. They thus find the 'harsh' confrontation tactics distasteful and offensive and fail to appreciate their value in inducing constructive behavioral changes and personal growth."

For those who might think confrontation degrading and humiliating, Dr Carroll continued: "I would only say that the most degrading form of humiliation I can think of is for someone to remain locked into an addicted way of life."

To insure against abuses, institutions that use confrontation techniques should periodically re-examine the effectiveness of this form of treatment and decide whether it is still ethical and appropriate to the need of patients.

Dr Carroll concluded: "The ultimate test of the ethics of any treatment strategy is whether it reflects a basic respect for the dignity and worth of the individual being treated and whether he or she is being afforded adequate protection for his or her physical and psychological well-being, and finally, that his or her basic human rights are not being cruelly and unnecessarily abridged.

"I believe confrontation tactics, done responsibly, do not constitute a branch of these criteria."

Is medicine ignoring alcoholism?

WASHINGTON — Alcoholism is now considered a disease, but it is a disease that some regard as not relevant for doctors to treat.

This is a paradox that needs to be addressed publicly, in the opinion of Gerald Klerman, administrator of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) in the United States.

Dr Klerman points out: "The primary treatment resources are seen as para-professionals, often former alcoholics. In many alcoholism treatment centres, there is an anti-medical, anti-psychiatry, and anti-medication bias."

Such a situation does a disservice to the alcoholic patient, Dr Klerman believes. There are roles for medical and psychiatric practice in caring for the alcoholic in diagnosis, detoxification, and treatment evaluation.

One of the most important subgroups among alcoholics are those who develop a secondary depression. There are now valuable new treatments for depression, including lithium and anti-depressant drugs, and preliminary indications are that they are useful for alcoholics who are depressed.

A number of studies show that many patients can be detoxified in community facilities. The capacity for this form of treatment depends on availability of medical backup.

Dr Klerman said many doctors can assume an important role and make a contribution in treatment assessment. This is particularly relevant, as many treatments have been only partially evaluated by techniques such as the double-blind controlled trial.

Dr Klerman said doctors in their practice should always consider the adverse consequences of alcohol when used in combination with other drugs, whenever they write a prescription for a patient.

He said they also should routinely check and document the history and pattern of alcohol consumption for individual patients to determine both the possible alcohol-relatedness of presenting pathology, as well as the potential for drug-alcohol interactions.

Ban tobacco promo: WHO report

By Alan Massam

LONDON — The new British Government, freshly installed under the country's first woman prime minister, Margaret Thatcher, has been urged to put a total ban on all forms of tobacco promotion.

Margaret Thatcher: will she ban all tobacco promotion?

The advice comes from a World Health Organization expert committee in a report "Controlling the Smoking Epidemic."

It says the international tobacco industry's "irresponsible behavior and its massive advertising and promotional campaigns are, in the opinion of the committee, direct causes of substantial numbers of unnecessary deaths."

The WHO group concludes that responsibility for action rests on governments and emphasizes there is need for urgent action in the developing countries.

At a press conference to introduce the report here, chairman of the Royal College of Physicians anti-smoking lobby group, ASH (Action on Smoking and Health), Dr Keith Ball, said it would be welcomed by Britain's doctors.

Chairman of the expert committee, Sir George Godber, said: "We must call for real action from government now. The time for half measures such as we have had hitherto is past. We have a right to expect Parliament to respond forcefully and effectively on the lines of the recommendations."

The WHO report recommends that non smoking should be regarded as normal social behavior; that there should be a total prohibition of tobacco promotion; that tobacco exports should be discouraged; and that all exported tobacco products should contain no more toxic substances than the same brand in the country of origin.

Drugs improperly prescribed to elderly

By Betty Lou Lee

OTTAWA — Prescribing habits of physicians in the Ottawa Civic Hospital family medicine centre show inappropriate use of benzodiazipene among older patients. They were being given long-acting preparations, rather than the shorter-acting ones recommended for the aged, and being given them for longer periods of time than younger patients.

W. W. Rosser, director of the centre and associate professor of family medicine at the University of Ottawa, says he thinks the finding is "probably universal" and not peculiar to this centre.

He presented the results of a one-year study of the use of this drug group to the 25th anniversary meeting here of the College of Family Physicians of Canada.

Diazepam (Valium), with a half-life of 31 hours, was used twice as frequently for these patients as chlordiazepoxide (Librium), which has a half-life of about 10 hours. In women over 65, it was used 4.6 times as frequently, a situation for which "there is no clear pharmacological rationale," said Dr Rosser. A significant number of those over 65 were also given flurazepam (Dalmane) which has a half-life of 52 hours.

For this age group, 38.5% of the diazepam prescriptions were for longer than six months, and "that needs to be questioned."

Dr Rosser found that per capita prescription of the three drugs studied increases with age, but in an interview he didn't think the percentage of elderly people getting benzodiazipene was inappropriate: it was the type and duration of the drugs he was concerned about.

"This is the age group that has difficulty sleeping, because of lack of exercise, and has more minor aches and pains."

The recommendations in the medical literature, he noted, say that because of reduced liver function, benzodiazipene stays longer and produces more adverse side effects in the elderly. Therefore, it should be used with more caution, and the shorter-acting forms are preferable.

But he found just the opposite was happening: they were more likely to be given a long-acting form and for longer periods.

"Oxazepam, (Serax) although slightly more expensive, has a clear advantage over the three drugs studied in that it has a shorter half-life (mean seven hours) and is metabolized to an inactive glucuronide reducing the influence of liver function, age, and serum protein levels on the half-life.

"The characteristics of oxazepam compared to the three drugs in the study are important because of cumulative tendencies of the three drugs, especially when prescribed more than twice daily. Peak cumulative effects of chlordiazepoxide are achieved in three days, diazepam in seven days, and flurazepam in 10 days."

The centre's five family physicians and 23 residents care for about 13,000 patients. In the study year, they wrote 12,170 prescriptions, of which 860 were for the three forms of benzodiazipene.

Middle East meets the West to reduce illegal drug trafficking

By Thomas Land

AMSTERDAM — Police and customs authorities in Western Europe are establishing direct links with their opposite numbers in the Middle East in the hope of reducing illegal drug trafficking, which has intensified.

The international framework for such direct cooperation has just been established at a meeting brought together under the auspices of the United Nations Commission on Narcotic Drugs. The practical arrangements, which are now being worked out, are essentially for a rapid exchange of information and the pooling of experience and, when necessary, resources in a common approach taken by the authorities at both ends of the illegal market.

The UN-inspired meeting of police and drug specialists was held in Geneva, leaving the national enforcement authorities to make their own arrangements. Specialists in liberal Amsterdam, which pays a disproportionate social price for Europe's drug abuse problems, are optimistic.

The joint venture is modeled on a similar collaborative effort involving the law enforcement authorities of Western Europe and Southeast Asia; late last year, it resulted in the dismantling of an important network of traffickers operating between Singapore and several prosperous European cities, including Amsterdam.

The "spiraling international traffic in opiates" originated from the Middle East and, as one specialist put it, is fed by recent turmoils and periods of breakdown in public order in countries such as Afghanistan, Iran, and Lebanon. There is evidence of growing involvement by organized syndicates with access to substantial financial support enabling the traffickers to develop a broad criminal infrastructure.

A spokesman for the UN commission says "the illicit traffic is complicated by the tendency to use more couriers making interception more difficult, and to seek out new routes using smaller transit centres, particularly in Western Europe. And the volume of the traffic is growing rapidly."

Earlier this year, a world conference on narcotic drugs called for the establishment of close, practical co-operation between the law enforcement authorities of Europe and the Middle East, and invited all governments to establish a machinery (possibly through the appointment of drug control liaison officers at their embassies) to assist each other in their efforts to curb trafficking.

And the UN's International Narcotic Control Board is seeking arrangements for "a stricter investigation (of) the movement of capital which is destined for the financing of international trafficking, thereby making it possible to identify the financiers who are the real organizers of the traffic."

The police and customs authorities of Turkey already receive substantial financial and organizational assistance from the specialist UN agencies to reduce the transit traffic of drugs to Europe. Such assistance may shortly be extended also to Romania, Bulgaria, and Yugoslavia, which have recently emerged as a principal transit zone.

But the success of the Middle East scheme essentially depends on the ability of the law enforcement authorities of the consuming and the producing countries to work together against their versatile common opponent.

Sex a factor in treatment

KING OF PRUSSIA, PA — Substance abusers who are homosexuals require different considerations from heterosexuals during treatment and pose a number of ethical dilemmas, in the experience of Thomas Ziebold, PhD, Whitman-Walker Clinic, Washington, DC.

Dr Ziebold told the annual Eagleville conference here that recovery from chemical dependence involves major changes in attitudes and behavior and often a reassessment of basic social values.

It is not possible to say what is best for the homosexual client in social terms, because he or she is cast, by definition, outside conventional society and into a subsociety that only now is developing traditions.

Dr Ziebold said a major problem for counsellors is whether a homosexual in recovery treatment be confronted "and urged to disclose his or her homosexuality in the name of 'leveling' for full participation in the group process."

He asked: "What do we do with the certain knowledge that a client is gay if the client's denial is adamant? What do we do with the strong suspicion that a client is deeply troubled by the knowledge of being gay and still refuses to deal openly with this knowledge of self?"

There seems to be considerable evidence that self-disclosure of homosexual orientation, as self-disclosure of other secrets, is beneficial to recovery of homosexual addicts. However, Dr Ziebold added, "there are questions as to whether this is appropriate for all people and how forcefully the disclosure should be urged."

Dr Ziebold acknowledged: "The ethical issues are not easy, just as homosexuality is not an easy issue in our society." However, the overriding interest "must be to promote recovery and comfortable sobriety and this can only be achieved in an atmosphere of acceptance and assistance of the homosexual in exploring what it means to be homosexual."

Student bartenders study alcoholism

By Manfred Jager

WINNIPEG — University of Manitoba students who work as part-time beer and wine waiters in their Students' Union Pub are getting an education — in responsible liquor enjoyment and alcohol abuse prevention.

"We were very much impressed when the University of Manitoba Students Union called us a few weeks ago and asked us to help them with this program," Colleen Allan, a training officer with the Alcoholism Foundation of Manitoba (AFM), said recently. "They were renovating and expanding their pub and wanted to do what they could to promote more responsible drinking from now on."

Ms Allan said four weekly training sessions of between 15 and 20 staffers at the pub will be concluded soon.

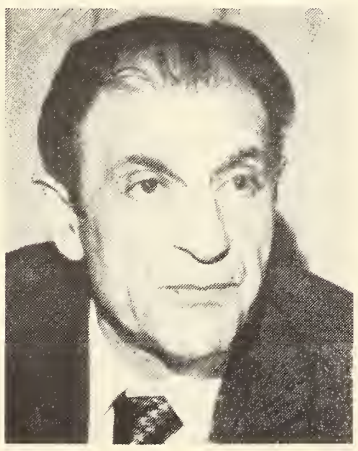
"We're telling these people what to watch for in their customers, how to go about stopping them from drinking more than is good for them, and how to impart the idea that you can enjoy a drink without having to get stinking drunk."

The main point which must be made to both staffers and their customers at the student pub is that anyone who takes a drink is also putting a drug into his system and must be aware of that, Ms Allan said.

"It's not only a question of changing the drinking habits of those who go to the pub, but also of making sure the people who serve them know what they're doing in their inter-personal relations and have sensible attitudes toward liquor themselves," the training officer said.

She said plans call for the training program to be coupled with a poster campaign in and near the pub, reminding patrons to use moderation in their alcohol intake.

Down the DC drains



Former Iranian ambassador Ardeshir Zahedi.

WASHINGTON — Islamic Republican fever and strictures against alcohol caused staff at the Iranian embassy to pour $22,000 worth of liquor and fine wines down the drains of the District of Columbia.

Action by embassy staff was on direct orders from Ayatollah Khomeini. Former Ambassador Ardeshir Zahedi was one of Washington's best known hosts and kept a fine cellar.

Iran Air, which considers itself now "the flag carrier of the Islamic Republic," has stopped selling liquor on all flights.

At this salon they dried 'under the influence'

By Alan Massam

LONDON — The apparent enthusiasm of some women for frequent visits to the hairdresser may be explained by public health enquiries in the West of England.

One perplexed hair salon owner complained that his staff was experiencing feelings of light-headedness and general symptoms of intoxication.

Initial concern about the discharge of carbon monoxide from heaters in the establishment proved to be unfounded.

Then a local environmental health officer started investigating hair lacquer used in refillable plastic atomizers and found the major solvents were ethyl alcohol and iso propyl (alcohol in the proportions 65% and 17% respectively).

The question which therefore arose was — were the staff and their customers getting high on the haze?

The advice of the Avon and Somerset police forensic science laboratory was sought. It came to the conclusion that inhalation of the vapors could well be producing the symptoms described, particularly if ventilation were poor and a build up of the vapors was allowed.

Subsequent breathalyzing of four employees in the salon after a morning's work, however, indicated there was little cause for alarm.

There was no risk of customers or staff leaving the establishment and subsequently being charged with Drying under the influence or even Drying without due care and attention.

The proprietor of the establishment did improve his ventilation, however.

Source: Environmental Health, Journal of the Environmental Health Officers Association, vol. 87, no. 5, May.

Warning: silicon particles may be harmful, too

By David Milne

SAN FRANCISCO — Smokers concerned about what they are inhaling can add another item to their list.

The newest potentially harmful ingredient is silicon.

Duke University pathologists reported this finding to the annual meeting of the United States-Canadian section of the International Academy of Pathology here.

While most researchers studying tobacco have looked at tars and vapors, Drs Hal Hawkins, Peter Ingram, Philip Pratt, and John Shelburne at Duke, and Dr Bill Gutknecht at The Research Triangle Institute have undertaken a detailed study of solid inorganic particles in tobacco and smoke.

Using a variety of modern methods, including scanning electron microscopy, energy dispersive x-ray analysis, and mapping techniques, they found "tobacco has an undulating surface, littered with innumerable small, angular particles."

Ranging in size from a mere half micron to 20 microns, most particles are made up of various combinations of calcium, phosphorous, sulfur, iron, and other harmless elements.

But their major finding was numerous particles of pure silicon and others of silicon and aluminum, all in the inhalable range.

Chemical analysis of four popular brands of cigarettes later showed that each cigarette contained an average of 3.6 mg of silicon and 0.45 mg of aluminum.

Is there a potential hazard to smoking tobacco that contains soil particles?

Although silicon could be an intrinsic part of the tobacco plant, there is strong evidence that it is a contaminant from the soil.

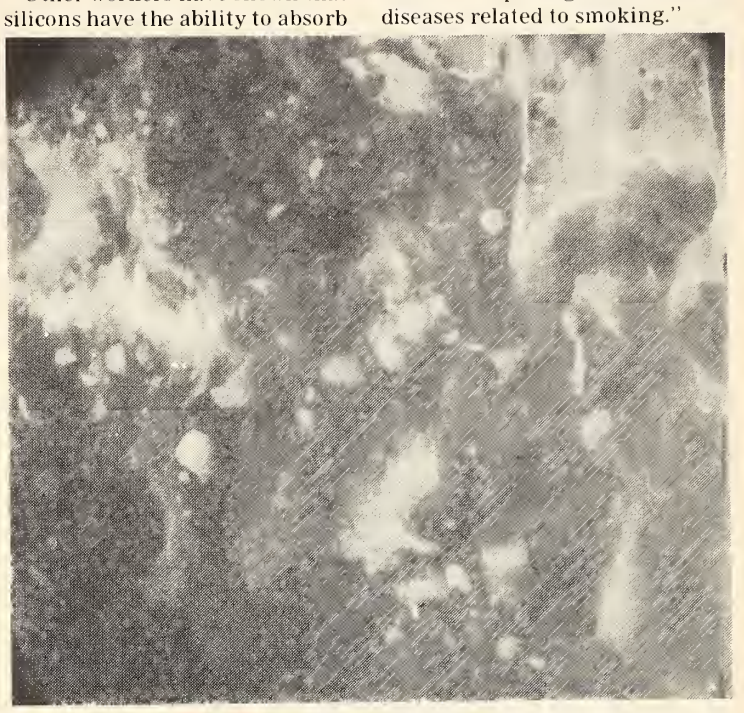
"Yes, there is a potential hazard, although as yet we do not know how harmful these particles are as we have not studied their toxicity," Dr Hawkins said in an interview here.

"It is well known that the most common forms of silica are capable of dissolving cell membranes and kill macrophages (cell scavengers) found in the lungs, so they are biologically active particles."

Other workers have shown that silicons have the ability to absorb hydrocarbon carcinogens.

Other members of the Duke University team have shown that the same silicon particles on the leaves are carried into the lungs via smoke in a very small yield.

Based on their work so far, Dr Hawkins said: "We suspect that the presence of these particles in tobacco may prove to be significant in the pathogenesis of lung diseases related to smoking."



Tobacco magnified several thousand times by scanning electron microscopy reveals undulating surface scattered with thousands of particles of silicon, aluminum, calcium, phosphorous, sulfur, iron, and other crystals. All are small enough to be inhaled and range in size from 0.5 microns to 20 microns. It is estimated that one-half million silicon particles are in the smoke from one cigarette.

Ozone and safer cigarettes

By David Milne

DALLAS — Scientists have developed a method that may render tobacco less harmful.

It involves using ozone, the substance that screens out harmful sun rays, to decompose dangerous compounds in tobacco called polynuclear aromatic hydrocarbons.

A. I. Shepartz of the United States Department of Agriculture's (USDA) Tobacco and Health Laboratory in Athens, Georgia, told delegates to the Federation of American Societies for Experimental Biology the method eliminates from tobacco leaves the substances responsible for formation of tumor-producing hydrocarbons.

Dr Shepartz and colleagues, Dr J. Ellington and W. S. Schlotzhauer, found most hydrocarbons produced in the burning process come from a small group of components in the tobacco leaf. These components are known as lipids, a class of compounds made up of waxy or fatty substances. In their recent work, the researchers developed a method for decomposing these lipids in the tobacco leaf.

When the treated leaves are burned, significantly fewer hydrocarbons are produced.

Dr Shepartz said the method consists of treating tobacco with ozone, produced from oxygen by an electrical discharge. The ozone causes an oxidation reaction and a decomposition of the compounds from which the polynuclear aromatic hydrocarbons are derived. Thus, when the tobacco is burned, fewer hydrocarbons are produced.

The investigators said: "These findings indicate it should be feasible to treat tobacco with ozone on a large scale, thus producing safer cigarettes and resulting in a reduction in the incidence of lung cancer." More research is needed, however, comparing the health effects of ozone-treated tobacco with those of untreated tobacco, they said.

'Pharmacologic roulette': unintended suicide

CHICAGO — Drug abuse plays an important role in suicide attempts by children and teenagers. However, the "kick" or "trip" motivation in self-poisoning is only of low or medium lethality.

So two researchers told the annual convention of the American Academy of Pediatrics, based on a study of 1,103 cases of self-poisoning in children and youth aged six to 18 who were seen at 50 poison control centres.

On a continuum of seriousness, from less lethal to highly so, Drs Matilda McIntire and Carol Angle put the "kick" or "trip" motive second, after accidental poisoning. More serious in nature were suicidal gestures, and actual suicides, or attempts.

Unfortunately, however, the adolescent who is abusing drugs to the toxic level has very little understanding of their effects and is, in effect, "playing pharmacologic roulette." Of the six deaths reported in children over 15, they said, none was intended.

The greater danger to adolescents is also shown in the fact that while there is only one fatality for each 6,250 events with children under that age, the fatalities rise to one in 200 over the age of 15.

The youth who is abusing drugs, they said, is ambivalent about dying, but plays either a partial, covert, or unconscious role. This abuse is similar to other self-destructive tendencies such as being foolhardy, or careless, or failing to seek life-saving medical care.

Suicide is the third leading cause of death in the age group 15 to 25, they said. Also, self-poisoning is by far the most common mode of suicide gesture, and accounts for one-fourth of the fatalities.

The physicians noted that a smaller study, in which 50 consecutive self-poisoners in Omaha were compared with 50 matched controls, showed that almost all of the former reported long-standing personal difficulties. The suicidal gestures were made at the time of a compounding stress — usually one of "the five Ps — parents, peers, privation, pregnancy, and punctured romance."

Major differences were also found, between subjects and controls, in the areas of hostility, depression, and parental rejection, they said.

In all socio-economic groups, there was also a significant amount of alcoholism — 44% of the subjects, and only 15% of the controls. This suggests a relationship between alcoholism and suicide, both self-destructive behaviors, they said.

"The relation of parental alcoholism to self-destructive behavior in the child deserves further investigation."

At the same time, they said, some of the young people who themselves abused alcohol or other drugs were considered in a "low risk" group for recidivism, according to a study of 26 subjects available for followup. The six "low risk" individuals in the group "had all made gestures of negligible lethality of intent — predominantly drug and alcohol, and alcohol overdosages."

While these young people had a high incidence of antisocial, delinquent behavior, they did not have disturbed thinking, as some of the higher risk youth did. Still, the researchers said, 40% of the high risk subjects did make repeat suicidal gestures within two years and in them, alcohol and drug abuse was common.

'Martyr' mates keep alcoholics ill

By Pat McCarthy

PALMERSTON NORTH, NZ — The wife who becomes a "saving martyr" while her abusing husband sinks into alcoholic disease actually plays an important role in keeping him ill, according to Victoria M. Fries, assistant director of the Dr Phillips Alcoholism Treatment Center of Bethel, Alaska.

"She starts to enable his sickness as she gains more and more family responsibility and power, something she's reluctant to give up should he start to get well," she said at the New Zealand National Society on Alcoholism and Drug Dependence meeting here.

"Everyone, of course, recognizes what an awful burden she has and gives her much needed sympathy. Unfortunately, this is done in such a way as to encourage her to carry on her behavior rather than to seek any improvements."

Ms Fries said the whole family develops rigid roles around the illness, which hurts all of them as they seek love and attention any way they can get it.

The alcoholic and abusing husband most likely will have a deep sense of guilt and anger but have difficulty expressing these feelings positively.

"He often blames those around him for his problems and will generally not be able to see his own need for help. What one often finds deep inside is a very scared, insecure person, who gains ego strength belittling those around him. He is hurting but does not want to let anyone near."

There are many reasons why an abused woman returns to a violent home situation, she said.

"If they are not experiencing a martyr syndrome, one should realize that these women love their husbands and they hope he will soon return to what he was like when they married him. Often, too, women don't have any money with which to leave, and no training or skills to overcome that handicap. Some women even fear for their lives if they should leave.

"Then, too, one must be aware of the law of inertia, so true in many counselling situations. It is easier to return than to try to change a seemingly hopeless situation. The mere thought a woman may have about creating waves and rocking the boat probably doesn't seem worth it to her at this point. If she is depressed she will unlikely have enough energy to do more than get through her day."

Many professionals are eager to split a family up, to help the woman become "liberated and happy," Ms Fries said.

"Many fail to understand why she returns to the man, and give up on her when she does. Unfortunately, she then loses her first real ally, someone who could have really been the impetus into helping the family."

In helping an abused woman, a counsellor should not forget that other family members desperately need help and understanding. If the husband will not come in for counselling, he may begin to learn through the woman and children once they understand the situation and begin to cope more effectively with it.

If there is an alcohol or dependency problem in an abuse situation, it must be addressed before other problems can be resolved, she said.

Cocaine, arthritis, don't mix

BETHESDA, MD — Arthritis experts have been quick to point out the fallacy of a California doctor's claim to have cured arthritis patients with cocaine and Darvon.

The purported cure may be worse than the disease and could lead to addiction, according to John Decker, clinical director of the National Institute of Arthritis, Metabolism and Digestive Diseases here.

His remarks followed the announcement by a Kelseyville physician that he had successfully banished the painful symptoms of 13 arthritis patients with cocaine and Darvon.

Dr Decker said: "There are times when you have to give arthritis patients medicine to relieve pain but physicians are constantly trying to make sure people don't become addicted to it. That can be a worse monkey on your back than joint pain."

The only pain-killing medications of real value against arthritis are those which also reduce the inflammation in swollen joints. The most common treatment, Dr Decker said, is large doses of aspirin. Cocaine and Darvon do not have anti-inflammatory power, Dr Decker said.

The unorthodox treatment brought the physician under scrutiny by the state Board of Medical Quality Assurance, but no action was taken.

Sailors, admirals, celebrities treated equally at Navy rehab centre

By Harvey McConnell

WASHINGTON — Any alcoholic patient who enters the Naval Regional Medical Center, Long Beach, California — ordinary seaman, admiral, or public figure — receives exactly the same course of treatment.

Captain Joseph Pursch, chief of the alcohol rehabilitation service at the centre, says: "Our predominant philosophy is that alcoholism is a disease, it appears the patient has it, and treatment now begins."

The Long Beach facility is primarily for naval personnel but can accept civilians if the secretary of the navy so designates. In recent years, several public figures have been patients there (Betty Ford, Billy Carter, and Senator Herman Talmadge among others).

Billy Carter: public figures receive exactly the same treatment.

Captain Pursch told **The Journal** some of the centre's attractions are that patients know it is located in a hospital, "that we have a pretty decent success rate, and it is also well known that we can provide better security."

The most important factor in treatment is "we have a system in which no one can check out against medical advice. Patients know they are going to stay there for four or five or six weeks until we agree with them that they are well.

"Therefore, we waste no time trying to persuade anyone to stay. We can use the time trying to persuade them they have an illness and they don't waste any time trying to get out. They can use all their time trying to find out what to do about the illness."

Security is tight and reporters cannot enter the facility until invited. Captain Pursch says: "The press has begun to treat us very nicely because they know that we are no nonsense, that we make an honest statement when a patient comes in. No one is hidden: we have no secret patients."

When a public figure leaves the facility there is an open press conference "at which anyone can ask any question."

Captain Pursch, a keynote speaker at the annual conference here of the National Council on Alcoholism, said public life may introduce people to frequent opportunities to drink, such as Washington cocktail parties, "but I think there is no single element one can identify as causing alcoholism in certain categories of people.

"I think the enemy of the public figure who has alcoholism is the public, very much as it is in the case of other alcoholics. That is, we, the rest of us, are reluctant even to suspect, let alone say, there is any such thing as alcoholism in someone whom we may admire, or someone to whom we may look for guidance."

When a public figure does admit to being an alcoholic "people who run treatment facilities around the country can tell you there is a mass influx of those who seek treatment."

Treatment of patients at Long Beach is based on total abstinence, and group support by peers and friends of the patient. "Our two goals are that the patient will be totally abstinent and will return almost invariably to the same job he or she held before they came into treatment," Captain Pursch adds.

"What has to be addressed is the disease of alcoholism, and the patient, no matter how important, has to be brought back to the fact that his basic humanness has to be addressed."

The success rate at Long Beach averages 75%. This ranges from a 45% success rate among 18 to 24-year-old alcoholics, who are still in an identity crisis and not established in a profession; to 85% to 90% among middle class, middle aged people who have a family and who are successful with a profession or skill.

"The Navy today has five admirals and 242 recovering alcoholic medical department officers, among others, back on the same job they held when they were referred to treatment."

Betty Ford: inspiration to others with problem of alcoholism.

Following their discharge patients are cautioned not to take any mind-altering drugs and to avoid medicines, such as cough syrups and gastro-intestinal remedies, which contain a high percentage of alcohol.

Captain Pursch said he and his colleagues have found that 15 out of 20 men and women who work in the alcoholism field have great initial difficulty in dealing with the alcoholic because of their own cultural heritage. This includes a belief alcoholism is a moral weakness, and not a disease, because of alcoholism in their own families which they had tried to cover up.

Women and alcoholism: the social differences

There were two days of discussions on the special problems of women with alcoholism at the National Council on Alcoholism annual meeting in Washington, DC. Harvey McConnell reports on some of the papers presented.

Alcoholism among women is now in the open, but much of the focus does not take into account vast social and cultural differences that can dictate patterns of drinking as varied as those found in men.

"Certainly before the onset of alcoholism you have great differences between groups of people, and after the onset of alcoholism there are still very important differences between groups of people," said Kenneth Miller, Tufts University, about a study of the demographic variables among female alcoholics, carried out with Nancy Mello and Jack Mendelson.

Dr Miller said the study looked at the blood alcohol levels of 690 patients admitted to an alcoholism treatment facility and found these levels were related significantly to age, race, religion, nationality, and education. There were striking differences between black and white women alcoholics.

"We found that the black women alcoholics had the highest mean blood alcohol level of any group of patients, and it was higher than black or white male alcoholics. A large number had blood alcohol levels three or four times the level of legal intoxication," he added.

On average, the black women were younger than white women when first admitted and they had many more severe physical disabilities related to their drinking. Some 21% of the black women were married, compared with 43% of the white women, and 28% were separated, compared with 13% of the white women.

None of the black women over the age of 60 remained married at the time of admission. Dr Miller said this group must be studied further, "as we might be dealing with a group who are very, very socially isolated."

Hypertension, liver damage, and pancreatitis were much more common among the black women. Black women were less likely to accept referral programs that might offer the right kind of treatment.

Dr Miller said the study showed "there are certainly distinct groups of women alcoholics with distinctly different needs."

■ A simple questionnaire has proven extremely accurate in identifying women with drinking problems at Boston City Hospital and is now part of routine examination on admission to the prenatal clinic.

The questionnaire has been devised by Henry Rosett and colleagues as part of their investigation into the fetal alcohol syndrome. It has been administered to more than 1,500 patients over the past four years.

The questionnaire is printed on a small slip of paper that can be stapled to the clinical record. The questions asked:

- Smoking: How many packs per day?
- Beer: How many times per week?
- How many cans each time?
- Ever drink more?
- Wine: How many times per week?
- How many glasses each time?
- Ever drink more?
- Liquor: How many times per week?
- How many drinks each time?
- Ever drink more?

Lyn Weiner, a member of Dr Rosett's team, said: "We consider somebody who drinks 45 drinks a month, or six drinks on occasion, a heavy drinker. A rare drinker is somebody who never drinks, and moderate drinkers are everybody else."

The results of the simple test have proven just as accurate as use of longer questionnaires. "It looks so simple that many think it is almost too simple," Ms Weiner added.

However, "doctors are not generally known for asking about alcohol and we wanted something they could use easily and that would fit into the standard set of questions they ask."

The researchers have found that when a pregnant woman is shown to be a heavy drinker, she is very receptive to counselling.

■ A survey of 58 husbands of alcoholic women found that 81% of them said drinking by their wives interfered with their ability to to do their jobs.

The survey, by Marjorie Allman and colleagues at the Alcoholism Counseling Services, Glen Cove, New York, was made among husbands who attended an Alcoholics Anonymous meeting. They had a mean income of $34,500 a year and only 9% had divorced and remarried.

It was found that 50% of the husbands said they stayed at home often to take care of their wives; 75% had stopped accepting social invitations or inviting people to the home; 59% said their children had to do unfinished housework. Two-thirds of the women did not work outside the home.

Ms Allman said 78% of the husbands said their wives drove while they were drinking, although a majority tried to hide the car keys.

■ Delayed onset of menstruation has been found in 78% of the daughters of mothers who were heavy drinkers during pregnancy. In a control group of abstainers, only 45% of the daughters had a delayed menarche.

Lucy Rober, of the Long Island Council on Alcoholism, said the study was carried out among 103 women, including 42 members of AA. Although it was retrospective, previous studies have shown that women are remarkably accurate in remembering the year of their own menarche as well as that of daughters.

Late menarche was defined as beginning at least one year later than the current national mean, which for daughters today is 1.5 years earlier than their mothers. Interestingly enough, the delayed onset was found only in first daughters, and not in any younger sisters.

■ Many American Indian women living in the Los Angeles area are heavy drinkers when they are young but curtail their alcohol intake when they marry and have children.

This was one of the major findings of the first study ever carried out in the United States about drinking patterns among urban Indian women, according to Marcelline Burns, of the Southern California Research Institute, Los Angeles.

Without exception, the 302 women interviewed by Indian counsellors hated their life in the city and yearned to return to the reservation. They all disliked and distrusted white people.

Most of the women were Sioux or Navajo, were poor, and did not do well in the urban job market. Most Indian families never buy property because they want some day to return to the reservation.

All of the women drink only on social occasions.

What is most difficult for them is that in the Indian way of life, sharing is all-important and they are thus under enormous pressure to drink.

Research has little say in health decisions

By John Shaughnessy

TORONTO — Science has little to do with social policy, and the likelihood of any substantial change in this situation is low.

It's too much to ask of a democracy that research findings be translated directly into legislation and government policy, says Eugene LeBlanc, director of policy development and research for the Ontario Ministry of Health. And any notion of revolutionary change about scientific input in the policy making process will lead to an attitude of cynicism and depression.

Speaking to a group of researchers at the Addiction Research Foundation here, Dr LeBlanc said: "There can be more (scientific input) than we now have, so I'm not suggesting complacency.

"But, as scientists we should perhaps adjust our notions as to how much variance in the policy making process is a realisitic goal. Many factors are inherently not susceptible to scientific influence."

Policy decisions are by definition political, he said. The decision to act depends on public interest and awareness of the problem and, to some extent, on whether a possible solution is available. The effectiveness of the decision to act depends on how it's carried out, including how detailed regulations to implement a law are written.

"The administration may decide not to vigorously pursue certain policies even though required to do so by law, or decide not to implement them at all," said Dr LeBlanc. "So scientific input can be knocked off at several stages along the way."

He added that researchers attempting to affect public policy often observe barriers when dealing with policy makers. Dr LeBlanc feels these fall into three main categories — different analytical orientation, different decision making styles, and institutional barriers.

"Policy makers are often uncomfortable with different aspects of the analytical orientation of researchers. The policy maker likes the type of quantitation which is often not possible. He is very uncomfortable with uncertainty and tends to translate statistical probability into certainty. He also looks to the short term outcome since he wishes to reap the benefits of his decision politically."

The decision making style creates a barrier because the system of policy making is not set up on the basis of people bringing forward options or alternate hypotheses. "Each individual is expected to come (to the policy makers) as an advocate," said Dr LeBlanc. "They expect you to have only one viewpoint and to argue for one option." In addition, scientists tend to offer optimal solutions, but the policy making system tends to produce "sufficing solutions."

Policy makers also relate more easily to decisions having major impacts on few members of society than to decisions having marginal impacts on many. "A renal dialysis program is much more attractive than some change in policy affecting nutrition," said Dr LeBlanc.

Institutional barriers are also evident. The departmental or ministerial structure of government can present problems. For example a researcher attempting to affect public policies concerning the aged may find himself or herself dealing with different ministries reponsible for health, housing, and income assistance. The researcher may also find that the attitude of policy makers is that the status quo is acceptable although not optimal because of political acceptability. "If a policy is sufficing at a particular time, there will be considerable inertia about changing it," said Dr LeBlanc.

In addition the public reception or prestige of a particular field of research or a researcher affects its acceptance. In some cases who you are may be as important as the quality of work you do or the seriousness of the problem you are working on.

In Dr LeBlanc's view there are four basic areas of formal government public policy. The first is "normative policy" which includes statements such as "we ought to do something." The second area is "strategic policy" and it can be characterized by the question, "What can we do?" The third stage of policy is "tactical" and involves the decision "we will do this." Tactical policy development tends to produce legislation. The fourth area is "implementation policy," and this is largely reflected in the regulations accompanying legislation. This is the part that makes the "we will do this" come to pass, said Dr LeBlanc.

He feels the greatest potential use of research findings is at the implementation stage. With respect to normative policy, research findings often play a role in revealing a problem. Research can produce some answers to the question, "What can we do?" but the decision "We will do this" is rarely susceptible to much scientific influence. At the implementation stage, policy makers tend to return to research to try to get some hard base information to control a problem which science may have played a role in identifying.

Dr LeBlanc pointed out that the lack of credible information is a pervasive problem even when one wants to use research findings. In some of the important areas of policy making, such as health services and environmental health, this is particularly acute. "The investment in research in these areas is relatively small; relatively few good researchers work in these fields; and any number of reports point to serious gaps in the knowledge available in these areas."

Research in these areas is often further hampered by the fact that studies are difficult to carry out. Problems may arise in setting up control groups, or scientists may have to rely on animal experiments which lack credibility in the public eye.

Dr LeBlanc said the problem is sometimes compounded by "an excess of information."

"A large amount of the material we have is descriptive and does not attempt to provide leads for action or proposals. When proposals are derived, they often are clearly not politically feasible."

Finally, information of importance that is being pulled together and packaged in an attractive way for public policy purposes is often available only from those who have a vested interest in the outcome. "Data from private groups is often not available unless it buttresses the case of a particular group," said Dr LeBlanc. "Often two interested groups will argue different sides of an issue using their own studies — and these are the only ones available."

Eugene LeBlanc: The policy maker 'looks to the short term outcome since he wishes to recap the benefits of his decision politically.'

An 'alcoholic binge' helped in her delivery

ELIZABETH, NJ — Although alcohol has been especially contraindicated during pregnancy, it's now been shown to have potential benefit in alleviating premature labor.

Catherine Smith, a 33-year-old woman with a fibroid uterus, one previous miscarriage, and bleeding early in her second pregnancy, has produced suggestive evidence with her delivery of healthy twins after a prescribed "alcohol binge."

Alcohol prevents release of the hormone oxytocin which affects uterine contractions such as those occurring during sexual excitement or labor.

When she came to Elizabeth General Hospital here in her 26th week she was in labor. Dr Edward Goodkin began an alcohol drip, but expected the treatment would last only a few days.

However, each attempt at weaning the patient resulted in resumption of contractions.

The obstetrician then recommended such pleasant tasting cocktails as *pina colada*. Being a teetotaller, Mrs Smith could not keep them down.

Dr Goodkin, therefore, continued an intravenous infusion of 10% alcohol in a glucose and water solution.

The patient was finally dried out in her 32nd week. The four pound boys were delivered two weeks later by caesarean section. Since their five-minute Apgar scores were 9 and 10 respectively, Dr Goodkin believes there was no alcohol-mediated brain damage.

(The Apgar score is a numerical expression of the condition of a newborn infant. It consists of the sum of heart rate, respiratory effort, muscle tone, reflex irritability, and color.)

But, Dr Ming Yeh, associate professor of OB-GYN at New York City's Columbia University, says six weeks of alcohol treatment is quite unusual.

"Generally, a large dose is given for two hours to stop the contractions; then a tenth of that amount is given for 22 hours," he told *Medical World News*.

After that, the patient is sent home and told to drink a couple of glasses of wine a day.

Dr Yeh notes the concern generally felt about the effect of alcohol on the fetus, but adds that babies appear to be unharmed by it after the first trimester of growth.

Coronaries for the under-50s

HILTON HEAD ISLAND, SC — There are two reasons a person under age 50 gets coronary heart disease, according to a Mayo Clinic study.

One is cigarette smoking, and the other is a history of the disease at a young age in elose relatives.

Reporting these findings to a science writers' seminar sponsored by the American Heart Association, Valentin Fuster said 92% of the 335 patients studied, ranging in age from 25 to 50, had either a strong family history of coronary disease in first-degree relatives such as parents or siblings at an early age, or they had smoked at least 20 cigarettes a day for 10 years.

Following the initial study of young coronary patients, an attempt was next made to try to identify sueh people before they developed overt heart symptoms, said Dr Fuster. He was able to detect this in some asymptomatic young people by means of a platelet survival test.

Since cigarette smoking apparently directly injures arterial walls, this eauses an increased number of platelets to rush to repair the damage, he explained. This makes measurement of these small blood components useful in determining the state of the artery walls.

"We measured the platelet consumption in apparently normal people who were smokers, and we found that more than 50% of these people had an abnormal increase in platelet consumption," he told The Journal.

"Since we know today that platelets appear to be important in the development of atherosclerosis (bypermittingplaquesto form where the platelets gather) we can now see a link between platelets, smoking, and atherosclerotie disease."

While the techniques to detect platelet abnormalities could be used in individuals, it would be both complicated and expensive in large populations.

Rather, it would be better for everyone with heart disease risk factors, especially a strong family history, simply to quit smoking.

Dr Fuster believes, however, that many need either the help of stop-smoking clinics or, their first heart attack. And even then, he said, 25% of heart attack survivors continue to smoke.

Mother's BAL key to FAS

By Cora McCann

HOUSTON, TX — It is a mother's blood alcohol level and not how much she is consuming that puts her infant at risk for the fetal alcohol syndrome, if studies with pregnant mice hold true in humans.

Gerald Chernoff, assistant professor of pediatrics, University of California San Diego School of Medicine, has studied the fetal alcohol syndrome in various strains of mice since 1972. He told the American Association for the Advancement of Science here that different strains of mice fed the same amount of ethanol-derived calories show different degrees of malformation and fetal resorption.

These differences are not just due to genetic factors, however, since different strains showing the same blood alcohol levels show the same degree of malformation and resorption.

"If you do enough fancy studies, including the proper genetic studies, what it turns out to be is that it's the maternal blood alcohol level that determines the degree of insult," Dr Chernoff said.

"So if you use blood alcohol levels as your axis to plot malformations against, rather than alcoholic consumption, you find that all of the animals, regardless of strain, fall along the same line.

"The clinical implications of this are that if two women come to you and say they are consuming the same amount of alcohol, you can't right off say that they are at the same risk, because those two women may be metabolizing alcohol in a very different way, and therefore have very different blood alcohol levels and place their offspring at different risk for fetal alcohol syndrome."

The next step, Dr Chernoff said, is to learn more about the way different women metabolize alcohol. He is preparing a study of blood alcohol levels in non-pregnant women in San Diego, but said data from chronic alcoholic women will be hard to obtain.

"There are some ethical problems involved that we are trying to overcome now, so that we can look at blood alcohol levels in chronic alcoholic women over a period of time, and then, hopefully, talk them into programs for getting out of their alcoholism."

However, getting alcoholic mothers to cooperate in such a study would be difficult for other reasons as well.

"For the most part, these women do not go to their doctors regularly during pregnancy and, often, their first presentation is in the delivery room. As a result, any information on them is very doubtful as to its validity, and the cooperation of these women is not what one would hope."

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Blows against Gilbert's second-hand smoke

At a recent meeting of Toronto Board of Health, Alderman Richard Gilbert was quoted as saying that second-hand tobacco smoke "is unpleasant and uncomfortable, but it is not a health issue and the Board should not treat it as a health issue". In a subsequent article, Snuffing the myths of second-hand smoke, (**The Journal**, Feb) Dr Gilbert has not departed from his ill-informed and irresponsible position as the lead quotes him as saying "second-hand tobacco smoke is unpleasant and unpopular but not necessarily unhealthy."

To the contrary, a paper prepared in 1978 by Dr Jesse Steinfeld, United States Surgeon General, 1969-73, Dr Luther Terry, Surgeon General, 1961-65, and Dr N. P. Krikes, President of the California Medical Association et al says that "second-hand smoke is a *major* public health problem" (emphasis added). Dr Geoffrey Greene, in the *Journal of the American Medical Association* says second-hand smoke is "a major public health issue." The Report of the National Commission on Smoking and Public Policy concludes that second-hand smoke creates "a real, and sometimes extremely serious problem" for non smokers. One might reasonably conclude from these comments that passive or involuntary smoking is a hazard to one's health and that it is very much a "health issue."

Dr Gilbert addresses his comments to two groups: those who have pre-existing medical conditions which are adversely affected by second-hand smoke and those who experience discomforting symptoms when exposed to tobacco pollution. Let's examine these groups with his comments at hand.

Close to 70% of Canadians, including children, do not smoke, directly at least. Of this group a "minority" has pre-existing medical conditions such as allergic, cardiac, or respiratory diseases. It has been estimated that a total of 27% of the United States population falls in this category alone. We have no reason to believe that there would be any substantial difference in the size of this "minority" in Canada.

The health of this group, Dr Gilbert admits, may be adversely affected by second-hand smoke. A US Public Health Service report says:

"persons with chronic bronchitis and emphysema have considerable excess mortality under conditions of severe air pollution. In smoke-filled environments room levels of carbon monoxide and several other pollutants may be as high or higher than occur during air pollution emergencies."

The health impact of second-hand smoke on the fetus and infants in their first year is well recognized. Perinatal mortality increases when a mother smokes (smoking in pregnancy results in an estimated loss of 4,600 babies per year in the US alone) and infants who smoke "involuntarily" during their first year have double the incidence of pneumonia and bronchitis. If we add this group to those with pre-existing health problems, the "minority" becomes quite substantial in size.

If second-hand tobacco smoke is not a health issue as Dr Gilbert asserted to the Board of Health then, ipso facto, he is willing to write off this "minority" as not warranting protection from the Board. An interesting position to be advanced by a staff member of an institution concerned with drug abuse and its effect on society.

Let us look at the second group of non smokers, the "majority," those who, in Dr Gilbert's view, merely find tobacco smoke "unpleasant." There is no "direct evidence," he suggests, that the health of this group is at risk when exposed to ambient tobacco smoke. The World Health Organization defines health as:

"not only the absence of diseases and infirmity, but also the presence of full psychological, mental and social well-being".

Seventy per cent of the non smoking population may experience eye irritation when exposed to smoke and many others will suffer headaches, nausea, coughing, and other symptoms. These reactions represent something less than full health. Is Dr Gilbert seriously suggesting that these conditions are only "unpleasant" as the smell of garlic may be unpleasant?

What of the risks of long term exposure to second-hand smoke which Dr Gilbert says presents no risk to non smokers? Dr J. R. White and associates studied the lung function scores of 7,122 adults and found that non smokers who were exposed to tobacco smoke at work for long periods had pulmonary function scores almost the same as those obtained from light smokers. These scores are indicative of small airway disease and Drs Terry, Steinfeld, and Krikes say that this and other evidence reveals that second-hand tobacco smoke "can cause disease" in healthy non smokers.

The medical evidence is important. What is equally important is the way the evidence is interpreted. Dr Gilbert says there is no evidence that involuntary smoking causes cancer while Drs Steinfeld, et al, draw attention to the 40 carcinogens in second-hand smoke and caution that "neither is there evidence that second-hand smoke cannot cause cancer." Second-hand smoke has been shown to cause cancer in animals. Dr Samuel Epstein, an expert in environmental toxicology and carcinogenesis, says that "if a chemical causes cancer in well-designed animal tests, then there is a strong likelihood that it will also cause cancer in exposed humans."

Dr Gilbert tells the Board of Health that there is no evidence that tobacco advertising increases consumption and opposes the Board's attempt to remove tobacco advertising from Toronto transit vehicles while an exhaustive US Federal Trade Commission study looks at this question in depth and concludes that:

"the available evidence suggests that, contrary to the conventional wisdom of the (tobacco) industry, cigarette advertising does influence overall consumption".

Some of us who are trying to do something on the tobacco issue find Dr Gilbert's statements on direct and involuntary smoking misleading and sometimes erroneous. Your readers should be concerned that Dr Gilbert, a smoker, is the one who frequently speaks for the Addiction Research Foundation on the smoking issue.

Garfield Mahood
Executive Director
Non-Smokers'
Rights Association
Toronto

Dr David Stewart, BSc, MD, DECH, CCFP
Medical Advisor
Non-Smokers
Rights Association
Toronto

Editor's note: This letter included 14 footnotes, which are available from **The Journal** on request. Dr Gilbert replies next month.

More Letters...

Science must scrutinize 'psychosocial bias'

I would like to reply to the letter by Michael de Villaer regarding the possibility of alcoholism being an inherited disorder (**The Journal**, June).

The report in **The Journal** — Alcoholism an inherited disorder? (April) was a very brief extract of an hour long lecture entitled "Alcoholism and Genetics" which I delivered at the Addiction Research Foundation. The lecture was, in turn, based on a 60 page review prepared for Vol. 5 of *Research Advances in Alcohol and Drug Problems* (Ed. O. J. Kalant). I cannot condense the content of the review article into a letter and will therefore restrict myself to commenting upon the points raised by Mr de Villaer.

Firstly, there are seven adoption studies reported, not one as implied in Mr de Villaer's letter. The findings in six of the seven studies support the conclusion that prenatal rather than post natal factors contribute to the development of alcoholism in the offspring.

The main point at issue is whether or not the prenatal influence is genetic or otherwise in origin. The suggestion that alcohol intake during pregnancy in alcoholic females might influence the alcohol intake of their offspring has to take into account a number of factors. A majority of women of reproductive age drink alcohol, at least occasionally, and many continue to do so through pregnancy. Most pregnancies occur in women in their 20s and early 30s whereas alcoholism in women commonly presents in the late 30s and 40s. There is a considerable overlap in the alcohol consumption of women who will not become alcoholic and those who will become alcoholic at the age when both groups of women are most likely to become pregnant. Thus if alcohol has any effect on the fetus in terms of future alcohol consumption it would be unlikely to have differential effects on the offspring of alcoholic or non alcoholic mothers. The finding of a difference in the drinking habits of the offspring of the two groups of mothers indicates that the effect hypothesized by Mr de Villaer is unlikely to be the one operating in the adoption studies quoted.

The possibility that the wives of male alcoholics drink significantly more than the wives of non alcoholics when they are pregnant can be investigated and if supportive evidence is found for this hypothesis then consideration would have to be given to this possibility. Both of the above possibilities, however, imply a threshold effect of alcohol intake on the fetus which would be a very complex one involving the timing of the exposure of the fetus to alcohol, the frequency of the exposure, and the blood alcohol concentrations achieved by the mothers.

The possibility of a direct effect of alcohol on germ cells certainly exists and although Mr de Villaer downplays the genetic factors in such a situation it is only by the action of genetic influences that such a complex behavioral pattern as occurs in alcoholism could be mediated following germ cell damage by alcohol.

Mr de Villaer ignores the findings of Winokur's group demonstrating the association between affective disorders and alcoholism which have a familial pattern consistent with a genetic explanation for both disorders and in which alcoholism occurs without either parent being alcoholic.

The statement that "after two decades (actually it is more than three decades) of investigation, there is absolutely no evidence whatever for a genetic origin (of alcoholism)" is an expression of opinion by Mr de Villaer which he has arrived at, seemingly, on the basis of the reading of a minute portion of the evidence available.

I disagree most strongly with Mr de Villaer that there can be any "sensible bias" when one is involved in scientific investigation. Bias implies prejudice and preconceived opinions which have no place in science. It is such prejudice which has, until recently, hindered the investigation of many psychopathological conditions along any lines other than those predicted by a psychosocial model. I am not advocating that we abandon psychosocial explanations but I am advocating that we retain only those which can be supported by rigorous scientific investigation. As C. P. Scott wrote in 1926 "Comment is free but facts are sacred".

R.P. Swinson, M D, FRCP(C)
Staff Psychiatrist
Toronto General Hospital
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Associate Professor

'Ayatollah Muggeridge'

I note that the Old Master has lost none of his old punch. Who but Malcolm Muggeridge (**The Journal**, May) could have pulled off the brilliant coup of burlesquing the Ayatollah to the reverent questions of your correspondent?

I'll bet he had that cheeky, whimsical grin all over his face as he suggested, tongue in cheek of course, that now that Malcolm Muggeridge has discovered the Way and given up Wine, Women, and Weed, the rest of us benighted mortals ought to be grateful for his experience in these vices and spare ourselves the trouble of researching Sin for ourselves.

I did think the bit about the corruptness and the futility of television programs fell a bit flat though, since it jarred with the irony of the rest of his adumbrations; it is *true* that most television programs are trivial, pornographic mush.

But bravo for the bit about sex education causing teenage suicides, and for the regretful sigh at the fact that if it weren't for all those silly liberals screaming about getting the police out of our homes and bedrooms, we could summarily execute all those people suspected of taking chemicals of which the Ayatollah disapproves — and no legalistic nit-pickery about due process either. Brilliant!

In places though, if one were not aware that Mr Muggeridge is an intelligent man who earnestly believes that worthwhile moral decisions cannot be taken under state-imposed duress, one might have misread the whole tenor of his interview and come away with the impression that he really is a sanctimonious old bigot who would be thrilled to see people strung up for adultery and smoking pot.

Perhaps it would have been easier for the readers of **The Journal** to twig to the subtle irony of his remarks if he had told us, for example, how by irresponsible mistranslation of the New Testament, Jesus of Nazareth is commonly held to have changed water into wine, rather than the other way around, or if he had told us, still with that cadaverous Muggeridge grin, that what Jesus really said was, "Render unto Caesar even thy very soul," and then some.

My congratulations too, to your correspondent, Donald Gregory Bastian, for his fine portrayal of the straight man to the Old Master's incandescent comedy.

Michael Scott, MD
Vancouver, BC

Must be an error

Is there a printing error on page one of **The Journal** (Feb)?

You quote Canada's then Minister of Justice, Marc Lalonde, as stating ". . . the drug culture has started to ebb in our society."

Should you have correctly quoted the Minister, please let me know. I shall then write to you and your provincial counterparts across Canada. I want to be sure to receive the corrected versions of studies such as *Alcohol and Drug Use Among Ontario Students in 1977* which inevitably are going to have to be undertaken.

Also, so I'll be certain that the stack of letters sitting on my desk from anguished parents is merely a mirage.

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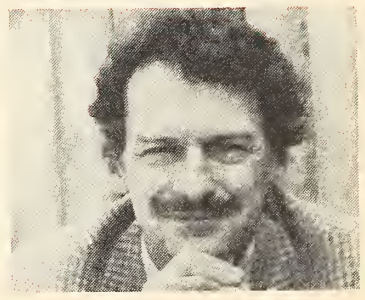
GILBERT

'The stage is set for a burgeoning of print on just how alcoholics actually go about the business of drinking . . .'



By Richard Gilbert

Are alcoholics different from you and me?

Mark Keller, the distinguished editor emeritus of the *Journal of Studies on Alcohol* (JSA), said it best in 1972 when he announced *Keller's law: The investigation of any trait in alcoholics will show that they have either more or less of it.*

Partial proof was offered in the form of a long list of physical, social, and psychological "demarcators" of alcoholism, compiled from memory. Keller noted that, compared with other populations, alcoholics have been found to be ". . . less mother-loved, more hepatitic, less hypertensive, more drug-consuming, less conditionable, more anomalous-alcohol-dehydrogenasic, less bucolic . . ." — to give just a brief extract from his list of more than 50 traits.

Objective observers of the alcohol scene might have surmised that publication of Keller's law would cause immediate termination of all research into alcoholism and personality. No such luck. The quest goes on, fortified by advances in computational technology. The first two sentences of a recent JSA article give the flavor:

"Complex statistical procedures are being used to analyse the interrelationships of variables that are presumed to be the ingredients of personality. These procedures allow speculation about psychiatric syndromes, one of which is the alcoholic personality, to follow a methodologically rigorous course."

Another recent JSA article reviewed "Alcoholism and the MMPI". The Minnesota Multiphasic Personality Inventory has "dominated personality research on alcoholics." Little consistency was found among the 132 studies that were discussed. Nevertheless, the author ignored the imperative of Keller's law and instead appealed for more research.

Behaviorists, too, are getting in on the action. Perhaps stimulated by Keller's final item — that alcoholics are "more thirsty" than other people -- studies in the early 1970s reported that the important distinguishing feature of heavy drinkers is that they drink more — of anything — and that they take longer draughts and rest less while drinking.

Recent observations of bar room behavior cast doubt as to the universality of the earlier conclusions. The stage is set for a burgeoning of print on just how alcoholics actually go about the business of drinking and on whether they do it differently from you and me.

If alcoholics are different, the differences may be inherited. Donald Goodwin, the most distinguished investigator of hereditary factors in alcoholism, commented earlier this year: "At this point we are not certain that *anything* is inherited." Later he wrote, "Possibly, if anything is inherited in alcoholism, it is *lack of intolerance* for alcohol," adding, with less reason, that "alcohol in genetically susceptible individuals may be massively reinforcing."

Thus, if we believe Goodwin, alcoholics differ from you and me in that they like the stuff more and hold it better. Goodwin proposed too that alcoholism results from the interaction of these inherited factors with circumstances such as having a dominant mother and a passive father, being second youngest in a family, and "the host of other psychological and social modifiers . . . described in the alcoholism literature."

Keller's summary to the article enunciating his law makes even more sense than the law itself. It read: "Alcoholics are different in so many ways that it makes no difference." For my money, the interesting question is whether it would make any difference if alcoholics were found to differ reliably from non-alcoholics in just one way. What would we do if they, and only they, were all born with green index fingers?

TYPOGRAPHICAL ERROR

One letter in last month's column was altered changing "proscribe" to "prescribe," and thereby muddling a key paragraph, which should have read as follows:

"It can be argued that unless society actually chooses to proscribe a drug, which has not yet happened with tobacco, people should be given an accurate balance sheet of the costs and benefits of using the drug, and left to make up their minds as to how to behave, at least in private. I agree with this position, as it applies to adults. Children are another matter. I feel that society has a greater obligation to protect the health of a child than to protect its freedom of choice."

Next month: Alcoholics Anonymous

Alcohol's Drug No. 1 for German youth...

HAMM, West Germany — Alcohol is becoming "Drug No. 1" among West German youth, according to the German Anti-Addiction Foundation (Deutsche Hauptstelle Gegen Suchtgefahren).

And Dr Bernhard Bron, a Bonn psychiatrist, recently described juvenile alcoholism as "a public health problem of the first magnitude."

It has been estimated that 120,000 to 150,000 West German teenagers are already dependent on alcohol.

The increase in youthful alcohol abuse has been steady and alarming over the past five years.

A 1973 survey conducted in Hamburg, for example, revealed that 25% of all pupils and students in that city aged 13 to 21 are inebriated at least once every two months.

In 1974 the Bavarian ministry of the interior conducted a survey that revealed 53% of young people between the ages of 12 and 24 consume alcohol several times a week.

Two years ago, a poll among 10- to 18-year-olds in Schleswig Holstein indicated that 85% of those queried consume alcoholic beverages with some regularity. Of those, 36% had taken their first drink before they were 10, and 38% between the ages of 10 and 12. Every fifth one had been "tipsy" at least once before the age of 13.

Fourteen per cent of those in the Schleswig-Holstein were described as "heavy drinkers," meaning that they consumed spirits, wine, or six glasses of beer "several times a week."

Dr Wolfgang Gruner, a psychiatrist in the Black Forest city of Freudenstadt, has described the young West German who drinks for the sake of inebriation "the prototype of a juvenile alcoholic.

"He doesn't drink because he likes the taste but because he is frustrated and wants to block out his environment," says Dr Gruner.

West German youth are considered especially susceptible to alcohol abuse and dependency because of a number of social and environmental factors that have put them under stress and pressure in recent years.

Because of changes in the educational system in the early 1970s and the baby boom of the late 50s and early 60s, there is a growing army of West German teenagers who cannot get the university educations to which they feel entitled and there are 100,000 at present who cannot get apprentice training because there are no openings. Another estimated 80,000 are jobless.

...while hard drugs hit countryside

ANSBACH, West Germany — Hard-drug trafficking and use in West Germany is becoming more of a rural and small-town than an urban phenomenon, according to police in Bavaria.

Dealers are believed to be shifting operations to smaller communities because they believe law enforcement agencies there are under-staffed, less vigilant and less experienced.

The case of this town, seat of an agricultural and small-manufacturing county in Franconia, is considered typical. The county has a population of 195,000.

Last year, local authorities recorded 182 cases of narcotics possession and abuse, compared to 96 in 1977. Of these cases, 75 involved heroin, compared to 41 in the preceding year.

Throughout the rest of the state of Bavaria, on an average, there had been a decline in drug cases.

Authorities, on the other hand, do not rule out the proximity of US army installations as a contributing factor to the increase in Ansbach county. There are three large military bases there and drug trafficking among and to the troops of the US Seventh Army in Germany has become a major problem.

Alcohol knowledge: in the cards

By Alan Massam

LONDON — A card game primarily intended for less-able British secondary school children has been produced by the Teachers Advisory Council on Alcohol and Drug Education. Devised by a professional card game inventor it has the specific objective of increasing knowledge about alcohol.

The pack is produced in thick, durable plastic and consists of two sets of 48 cards with teaching instructions. The game can be used over a period of two or three lessons and can be played many times.

The upward limit of children able to play at any one time is 20. The price of the game is £5.50

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Road lab to look at drugs

LONDON — The British Government's Transport and Road Research Laboratory is setting up a major study to assess the influence of a range of drugs on traffic accidents.

A pharmacological team will work closely with a clinical team to examine any effect of drugs on accident involvement.

The research, which is being carried out in collaboration with Oxford University, is described as "a welcome addition to multi-disciplinary research." It is linked with the Transport and Road Research Laboratory's major expansion of traffic medicine research.

Key researchers in the main program are Professor R. B. Duthie of the Nuffield Department of Orthopaedic Surgery, who is advising the laboratory on human and mechanical tolerance, and Professor D. G. Grahame-Smith of the university's department of clinical pharmacology.

3 new videocassettes from ARF

P878

Measure for Measure

23:50 minutes, color, ¾"
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Preview: $35.00 per week

An off-beat, informative look at the alcohol content of standard drinks and resulting blood alcohol levels. In a tavern setting Max the bartender spends an evening with his customers debunking some of the more common myths about alcohol and the way it affects our body. Delightful songs and graphics contribute to the surface fun while highlighting the message beneath. This light-hearted, entertaining look at alcohol is designed to heighten consumer awareness in a believable, non-moralistic manner.

P877

Cocaine

17:30 minutes, color, ¾"
U-Matic
Price: $140.00
Preview: $35.00 per week

Informative in a non-directive style, this is an intriguing exploration of a widely misunderstood drug. A party setting dramatizes the dilemma faced by a group of young adults concerning their potential use of cocaine. Without sensation or scare tactics the mystique and popular image of cocaine use is examined. A realistic, straight-forward film for young people . . . about young people . . . COCAINE gives the audience the information necessary to arrive at their own conclusions.

P879

It All Adds Up

11:14 minutes, color, ¾"
U-Matic
Price: $150.00
Preview: $35.00 per week

In a striking combination of film footage and historical photographs this documentary provides a powerful exploration of alcohol in our society. Concise, simple terminology helps to explain the complex issues of alcohol consumption, pricing policies, advertising, and regulations. Recommendations for government action are presented. This provocative, open-ended videotape provides a valuable discussion starter for groups concerned with the impact of alcohol on our social and economic life. The fast pace and basic information make it suitable for general audiences.

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Cameras turn on drinking students

AUCKLAND, NZ — A New Zealand school has driven home a lesson by filming pupils drinking and driving in a controlled experiment.

Nine fifth-form boys (aged 15 and 16) took part in the experiment at Rutherford High School, Auckland, conducted with the help of researchers from the Auckland Medical School.

One boy drank three 750ml bottles of beer and reached a blood alcohol level of 0.13%. Four boys drank two bottles each and had levels from 0.075% to 0.095% (just below New Zealand's legal limit of 0.1%). Four other boys who did not drink acted as controls.

Several parents watched as their drinking sons failed to drive a car between two poles after incorrectly judging the gap was wide enough to get through. The pupil with the BAL of 0.13% tried to drive through a gap that was 35cm narrower than the car.

Sel Evans, the teacher who organized the experiment, said it proved beyond doubt that youngsters lost reasoning and judgment when they combined alcohol with driving. Of the 350 pupils shown the film so far, many were surprised at the effect of drink on driving.

Mr Evans considers the film an important development in finding an effective way to teach young people about alcohol, because they are strongly influenced by what happens to their peers. If adults had been used, he said, the experiment might have been branded "another old-hat con."

Co-op method gains ground on Alaskan alcoholism

'Glimmer of hope' for NZ addicts

PALMERSTON NORTH, NZ — Kahunui Village is miles from anywhere, a tiny farm settlement in a remote valley surrounded by bush and hills.

New Zealand's first therapeutic community, it has an enviable success rate with drug addicts. Of 27 patients who have stayed there for the required minimum of one year, only three are not coping with life without drugs.

The key to Kahunui's success is the belief of its founder, Mildred Coursey, that "inside every human being there is a totally beautiful person, a person who can cope with life, who can relate to other people, and who can be a loving and caring person."

When young addicts arrive, she tells them: "What you have done, what you have been, is only an outside shell — inside you are a beautiful and worthwhile person. We are going to help you get rid of the outside shell so you can emerge as a totally confident and loving human being.

"Because I mean it — and they know I mean it — they have a glimmer of hope that perhaps they will be able to cope with life and all its problems without drugs," Mrs Coursey said here.

Mrs Coursey, a 56-year-old mother of five, runs Kahunui with her husband, Ken, and eight other therapists — all under age 30 and all people who originally came to the community to sort out drug or other problems. They do not receive any pay, just their keep.

Each patient (there are now 27 with a waiting list of 18) has his or her own therapist to whom he relates continually, building up a strong bond that is the medium for the therapeutic process. Being a therapist — an all-day, all-night job — means living the answer to the person's problems, Mrs Coursey said.

Therapy, farm work, gardening, cooking, and childcare (there are 10 children under age 7 in the community) are mixed with disco dancing, swimming, fishing, bush rambles, midnight barbecues, and even games of cops and robbers in the half dark.

"But none of these things would be of any value whatsoever unless, like us, you had a deep inner faith that human beings have an innate goodness, an innate beauty, and that they want to use it. It wouldn't work on an 8 am to 5 pm basis," Mrs Coursey said.

"You have to hurt when they hurt, be glad when they make some small progress, you have to understand them and love them and count every minute you all spend together as being worthwhile.

"You have to be proud of them, proud of every small achievement, you have to be as aware of them as though they were young children, noticing the things they do, a new haircut, cut foot, an altered dress, a change in posture, a change in feeling, any improvements.

"You have to be prepared to sit out possessiveness, demands, selfishness, unreasonable hostility. You have to be aware that for them time and attention is love."

PALMERSTON NORTH, NZ — A co-operative community approach is beginning to show positive results in combatting chronic alcoholism among Alaskan natives that has defeated previous traditional methods, according to reports at a special school on chemical dependency here.

The program has been developing over the past two years in the 25,000 square mile Kuskokwim Delta region. The town of Bethel, 450 miles west of Anchorage by 737 jet, is the hub for 56 villages there.

The area is only 7% Caucasian and depends on fishing and hunting for support. For a century it has been looked on as a backward region. Now it is developing into one of the most aggressive "bush" regions in Alaska.

"This is especially true with alcoholism control," says Francis Phillips, Anchorage, a veteran in chronic diseases who initiated Alaska's successful outpatient treatment of tuberculosis, formerly a pandemic scourge there.

"It is only in the past three years that very many people in the Bethel service area really believed that anything could be done about the problem of alcohol and drug misuse. Now it is becoming common knowledge that much can be done about it if we just help them learn how to do it."

For Alaskan natives (Indians, Eskimos, and Aleuts), problem drinking began with the arrival of Russian and European fur traders more than two centuries ago. Shrewd traders plied natives with liquor and defrauded them of their furs. And since Alaska was a territory of the United States before statehood in 1959, the 151-year prohibition of the sale of alcoholic beverages to American Indians did not affect the Alaskan natives.

Alcohol-related accidents are now the number one cause of death, followed by alcohol-related diseases such as cirrhosis. Crime among Alaskan Indians is seven times the national average, with 95% of these crimes committed while drinking.

The Indian Health Service says 70% of the native population over the age of 15 drinks — probably a "too conservative" estimate in the view of Dr Phillips, who tells of an 11-year-old Caucasian child drunk at noon in an elementary school, and groups of junior high school children arriving at school in the morning "quite well libated."

Prevention is a particular emphasis of the Kuskokwim Delta program, which Dr Phillips and four of his colleagues from Phillips and Associates, Anchorage, described here at a School on Chemical Dependency sponsored by New Zealand's National Society on Alcoholism and Drug Dependence.

Classes on alcoholism are taught every semester at the Kuskokwim Community College for the general public and workers in the alcoholism field. Village health aides are trained in managing alcohol misusers. Community therapy groups on alcoholism are organized and crisis intervention classes taught in the college. There are counselling classes for workers in alcoholism, and a coterie of counsellors in the Yupik (Eskimo) nationality is being developed. Teams of trainers go to the villages and train teachers in the kindergarten-through-secondary school mental health curriculum "Here's Looking At You."

"About the second grade we start giving them commonplace, honest information on alcohol and drug misuse," Dr Phillips said. "In the long pull, we believe that this K-thru-12 curriculum will do more than anything else to prevent misuse of alcohol."

Bethel itself was voted dry by its citizens six years ago, following several villages — mostly under Russian Orthodox Church control — that have had total sobriety for 150 years. (In some other villages, village councils maintain sobriety by their own "special methods.")

"To be sure, bootlegging has increased, but there are many visible evidences of betterment as a dry community," Dr Phillips said. "One example is less delinquency in the elementary schools."

Seven years ago it was not unusual for 25% of the fourth grade class in the Bethel elementary school to be absent the first three days of the week after joining their parents in binge drinking on the weekend.

Before the US government began in 1964 to fund treatment programs controlled and operated by the native peoples themselves, all traditional methods had failed with native alcoholics.

"Prior to 1964, all efforts to reduce alcoholism among Indian and native people were done *to* them by outsiders. After 1964, efforts were begun *by* them and they are successful," Dr Phillips said.

Now, he added, "the future looks good."

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

Jackson Junior High: Like Father, Like Son

Subject Heading: Alcohol and the family.
Details: 15 minutes, 16 mm, color, sound.
Synopsis: After a baseball game a father takes his son, James, to a bar where they meet some friends. Through their conversation, James realizes his father lost his job because of drinking. James tries to persuade the father to leave the bar but the father gets angry. At dinner, the parents are fighting, and again James' father drinks too much. Later, at the request of his father, James reads his school project on alcohol to him. His father takes it personally and hits his son. Subsequently, realizing the boy is not to blame, the father apologizes and promises to change his drinking behavior.
General Evaluation: Good to very good (4.5). Technically well produced, this contemporary, interesting, and realistic film had a clear message with strong emotional impact. Its length was suitable for most educational uses, and the film was considered to be an effective teaching aid.
Recommended Use: With the presence of a resource person, the film is likely to benefit audiences of 12 years of age and older. May be particularly useful to families with alcohol problems. It's not recommended for audiences 11 years of age and under.

A Slight Drinking Problem

Subject Heading: Alcohol and the family, attitudes and values, AA.
Details: 25 minutes, 16mm, color, sound.
Synopsis: Jimmy is late for his anniversary dinner. When he does arrive, he has obviously been drinking. Next day, Loretta is urged by her family members to get some help. Although she is not convinced that her husband has a drinking problem, she attends Alanon, where she is urged to "let him hit his bottom," not be a victim, and not to cover-up for him. After a particularly violent evening when furniture is broken, Loretta decides to leave things in a mess and not to call Jimmy's boss to cover-up for his lateness. When he comes downstairs and sees the mess he has created, he is jolted into saying that maybe he has a slight drinking problem.
General Evaluation: Excellent (5.9). A highly contemporary, informative, interesting, realistic and well produced film with a clear message and strong emotional impact, this film was deemed an excellent teaching aid. The A/V group liked what the film said about alcohol and its abuse and felt it could produce attitudes opposed to alcohol abuse and help in decision-making regarding alcohol use. Public broadcast was recommended.
Recommended Use: Likely to benefit general audiences of 12 years of age and older. Particularly useful to Alanon groups and employee assistance programs.

NEW MATERIALS FROM ARF

P-151 **DIAGNOSIS AND TREATMENT OF ALCOHOLISM FOR PRIMARY CARE PHYSICIANS** **$1.95**

A 36 page handbook on alcoholism developed for the primary care physician in conjunction with the Ontario Medical Association. A "how-to" guide dealing with identification, diagnosis, short and long-term management in both the medical and psycho-social senses. Invaluable to the medical practitioner.

P-160 **TEN LESSON PLANS FOR GRADES 7 AND 8** **$7.95**
P-161 **TEN LESSON PLANS FOR GRADES 9 AND 10** **$7.95**

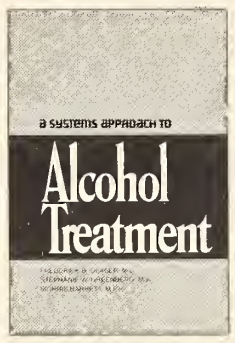
The program consists of two sets of 10 lesson plans. Each lesson deals with a separate topic and can be used independently. Developed in conjunction with the Toronto Board of Education. The lesson plans provide the teacher with as much information concerning alcohol and the process of teaching about alcohol as is possible. Includes suggestions for A/V and other materials to enhance the program. The Ontario Ministry of Education has reviewed the lesson plans and found them to fit Ministry guidelines.

GUIDES

A SYSTEMS APPROACH TO ALCOHOL TREATMENT

Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.
$14.95

A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



BOOK

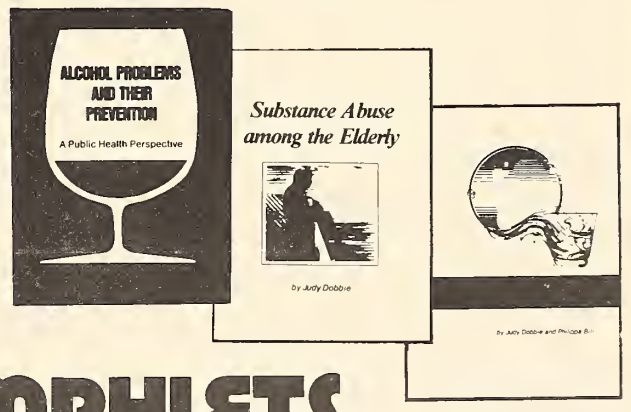
V-028 **MARIJUANA - THE FACTS** **$95.00**
25 Minutes, Color

Target Audience: Teachers, social workers, health professionals, and general audiences of mid-teens and older. Especially useful in learning or teaching situations.

Content: What is marijuana and what does it look like?
Is it addictive?
Effects compared to alcohol?
Does use lead to harder drugs?
Would use be beneficial for particular medical problems?

VIDEO CASSETTE

P-109 **THE FETAL ALCOHOL SYNDROME** **40¢ each**
P-110 **SUBSTANCE ABUSE AMONG THE ELDERLY** **40¢ each**
P-111 **ALCOHOL PROBLEMS AND THEIR PREVENTION —A PUBLIC HEALTH PERSPECTIVE** **40¢ each**



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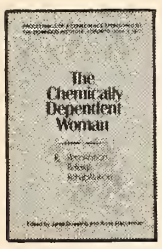

P-265 **$4.95**

THE CHEMICALLY DEPENDENT WOMAN

The published presentations resulting from a conference on women's issues, hosted by the Donwood Institute, Toronto. A distinguished group of presentors, including Dr. Gordon Bell and Ms. Jan Du Plain, address issues of usage, patient and physician perspectives, treatment trends, and new directions for women.

P-266 **$4.95**

SOLVENTS, ADHESIVES, AND AEROSOLS

The published presentations resulting from a seminar hosted by the Ministry of Industry and Tourism and the ARF on the use and misuse of these substances. The volume contains papers on historical review, legal considerations, community approaches to treatment, industrial perspectives, and a keynote address on international trends by Dr. Sidney Cohen of U.C.L.A.'s Neuropsychiatric Institute.

P-267 **$14.95**

INTERNATIONAL COLLABORATION: PROBLEMS AND OPPORTUNITIES

Proceedings of a two-day international seminar marking the designation of the Addiction Research Foundation as a collaborating centre of the World Health Organization.

Areas of discussion include: the epidemiology of alcohol and other drug-related problems, control strategies, and international collaboration in drug abuse programs.

PROCEEDINGS

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New Books

by RON HALL

Methadone Treatment in Narcotic Addiction

. . . by Robert G. Newman

The author presents a comprehensive account of the history, policies, management, and experiences of the New York City Methadone Maintenance and Ambulatory Detoxication Programs, which he directed from their inception in 1970/71 to 1975. These programs had more than 80,000 admissions during this period. The first part of the book presents the rationale for maintenance and detoxication treatment, planning and organization, management, and relationship with the community. Selected policy issues such as voluntarism as a criterion for admission, confidentiality, methadone dosage, and the irrelevance of success are discussed. The second part presents and analyzes data from these programs.

(Academic Press, 111 Fifth Avenue, New York, NY, 10003. 1977. 306p. $19.50)

The Outcome of Treatment: Patients Admitted to Hazelden in 1975

. . . by Sister Mary Leo Kammeier and J. Clark Laundergan

This report contains a sociodemographic profile and findings of a follow-up study of patients admitted to the Hazelden Rehabilitation Center during 1975. The chemical dependency treatment program is multidisciplinary in scope and emphasizes the importance of Alcoholics Anonymous participation. The profile of 1,503 patients has been developed from data gathered from intake interviews and treatment records. A treatment outcome assessment has been developed from data gathered from the 12 month follow-up questionnaire sent to all patients who agreed to participate in the study. The study indicated more of the non drinkers reported improvement on the maturation and growth items, indicated more participation in AA, had the lowest level of personal problems and arrest, and received more job promotions. Patients who reduced their drinking showed more improvement than was anticipated, and patients who used alcohol frequently showed more positive changes than were excepted. Although great similarities between men and women did exist on the broader outcomes, the internal items underlying those outcomes showed more variance than was anticipated.

(Hazelden Literature Department, Box 176, Center City, Minnesota, 55012, 1977. 67p. $4.95)

Other Books

Drug Addiction 11: Amphetamine, Psychotogen and Marihuana Dependence — Martin, W. R. (ed). Springer-Verlag, New York, 1977. Handbook of Experimental Pharmacology, new series, Vol 45, part 2. Includes bibliography and indexes. 510p. $100.55.

The Benzodiazepines: Use, Overuse, Misuse, Abuse — Marks, John, University Park Press, Baltimore, 1978. General dependence. Benzodiazepine dependence. Significance within the community. Appendices deal with analysis of reports of dependence. References, index. 111p. $15.

Phencyclidine (PCP) Abuse: An Appraisal — Petersen, Robert C., and Stillman, R.C. National Institute on Drug Abuse, Rockville, 1978. Papers, including references, presented at a conference, Pacific Grove, California, Feb, 1978. Neurobiology, neurochemical pharmacology. Recreational, chronic users, overdosage, psychosis, treatment. 313p.

Psychopharmacology Of Agression — Valzelli, Luigi. S. Karger, New York, 1978. Modern Problems of Pharmopsychiatry, Vol 13. Includes index and references. Sedatives, benzodiazepines, anti-depressants, cannabinoids, psychodysleptics, narcotic analgesics. 180p. $71.

The Journal

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

20th Annual Institute Institute On Addiction Studies — Aug 19-24, Hamilton, Ont. Information: Mr D. Smyth, Institute on Addiction Studies, 15 Gervais Dr, Suite 603, Don Mills, Ont, M3C 1Y8.

Summer School On Alcohol And Drugs — Aug 20-24, Calgary, Alberta. Information: Ms A. Steiestol, Conference Secretary, Summer School on Alcohol and Drugs, 812-16 Ave, SW, 2nd floor, Calgary, Alta, T2R 0T2.

4th Annual Symposium — Pharmacotherapy with Emotionally Disturbed Children — Sept 20-21, Toronto, Ontario. Information: Ms A. E. Parsons, Community Relations Officer, Thistletown Regional Centre for Children and Adolescents, 51 Panorama Court, Rexdale, Ont, M9V 4L8.

Input '79 — 3rd Biennial Canadian Conference on Occupational Alcoholism And Drug Abuse — Sept 23-26, Ottawa, Ontario. Information: Input '79 headquarters, Conference and Seminar Services, Humber College of Applied Arts and Technology, Box 1900, Rexdale, Ont, M9W 5L7.

Clinical Orientation To Alcohol And Drug Dependence Seminar — Sept 24-28, Nov 19-23, Toronto, Ontario. Information: The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ont, Ont, M4G 3Z1.

Detox Training Program — Oct 15-19, Nov 12-19, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

United States

21st Annual International School Of Alcohol Studies — July 15-20, Grand Forks, North Dakota. Information: F. Wittmann, conference coordinator, University of North Dakota, Continuing Education, Box 8277, University Station, Grand Forks, ND, 58202.

Annual Summer Institute Of Drug Dependence — July 29-Aug 3, Colorado Springs, Colorado. Information: Summer Institute of Drug Dependence, PO Box 2172, Colorado Springs, Co, 80901.

14th Annual Teenage Institute On Alcohol And Other Drugs — Aug 5-9, Gambier, Ohio. Information: Teenage Institute Coordinator, Ohio Department of Health, Division of Alcoholism, PO Box 118, Columbus, Oh, 43216.

11th Annual Summer School On Alcohol And Other Drugs — Aug 6-17, Berkeley, California. Information: Dr H. J. Kregel, Director, Berkeley Center for Alcohol Studies, Pacific School of Religion, 1798 Scenic Ave, Berkeley, Ca, 94709.

4th Annual Conference On Employee Assistance Programs In Higher Education — Aug 7-10, Newport, Rhode Island. Information: Employee Assistance Program, University of Missouri-Columbia, 215 Columbia Professional Building, 909 University Ave, Columbia, Missouri, 65201.

8th Annual San Diego Summer School And Drug Studies Program — Aug 19-24, San Diego, LaJolla, California. Information: Ms K. Lockwood, UCSD Extension, X-001, University of California, San Diego, LaJolla, Ca, 92093.

6th National Drug Abuse Conference — Aug 26-30, New Orleans, Louisiana. Information: NDAC '79, 115 S Chestnut St, Lafayette, Louisiana, 70501.

30th Annual Meeting Of The Alcohol And Drug Problems Association Of North America (ADPA) — Aug 26-30, Washington, DC. Information: Driscoll and Associates, 1925 North Lynn St, Suite 1001, Arlington, Virginia.

4th International Conference Of Therapeutic Communities — Sept 16-21, New York City. Information: Charles Devlin, coordinator, Daytop Village, Inc, 54 West 40th St, New York, NY, 10018.

Association Of Labor-Management Administrators And Consultants On Alcoholism (ALMACA) — Oct 2-6, Detroit, Michigan. Information: ALMACA, 1800 North Kent St, Suite 907, Arlington, Virginia, 22209.

Evaluation Of The Alcoholic: Implications For Research, Theory And Treatment — Oct 12-13, Farmington, Connecticut. Information: Mrs M. Meadows, Alcohol Research Center, Dept of Psychiatry, University of Connecticut Health Center, Farmington, Ct, 06032.

Annual Meeting Of The Society Of Forensic Toxicologists — Oct 31-Nov 2, Williamsburg, Virginia. Information: Robert V. Blanke, Medical College of Virginia, MCV Station, Box 696, Richmond, Va, 23298.

National Conference On The Problems And Preventions Of PCP Abuse — Nov 3-4, San Francisco, California. Information: Stephanie Ross, Haight Ashbury Training and Education Project, 409 Clayton St, San Francisco, CA, 94117.

Training Institute On Addictions — Dec 9-14, Miami Beach, Florida. Information: Training Institute on Addictions, c/o Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, Co, 80901.

Abroad

6th Institute On Drugs, Crime And Justice In England — July 3-20, London, England. Information: Arnold S. Trebach, director, Institute on Drugs, Crime and Justice in England, School of Justice, The American University, Washington, DC, 20016.

3rd World Congress Of The International Commission For The Prevention Of Alcoholism And Drug Dependency — Aug 26-31, Acapulco, Mexico. Information: ICAP executive director, 6830 Laurel St, NW, Washington, DC, 20012.

10th International Conference On Health Education — Sept 2-7, London, England. Information: The Conference Centre, 43 Charles St, Mayfair, London, W1X 7Pb, England.

International Conference On Alcoholism And Drug Dependence — Sept 3-7, Tegucigalpa, Honduras. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

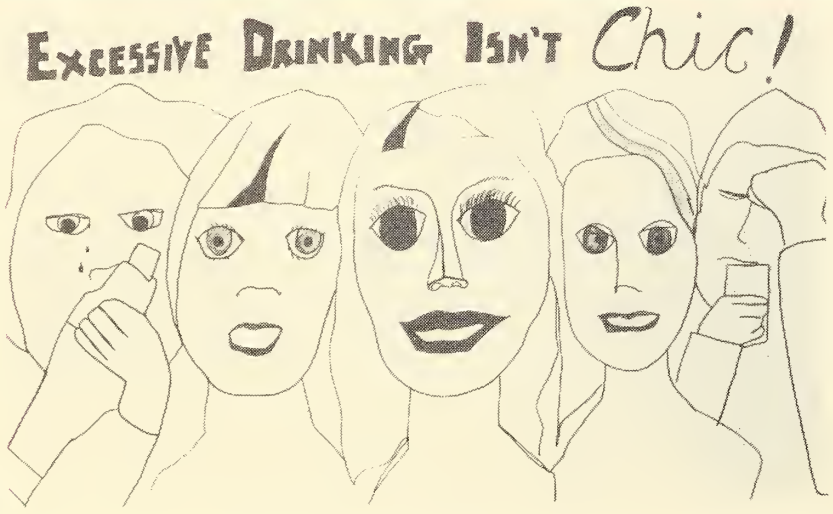
9th International Institute On The Prevention And Treatment Of Drug Dependence — October, Madrid, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1st Pan-Pacific Conference On Drugs And Alcohol — Feb 26-Mar 7, 1980, Canberra, Australia. Information: Pierre Stolz, AFADD, PO Box 477, Canberra City, ACT 2601, Australia.

ARF POSTER FESTIVAL

You don't need alcohol to be cool!

A surprising amount of natural graphic arts talent among Ontario's elementary and secondary school students was uncovered by the recently completed Poster Festival of the Addiction Research Foundation. Nearly 4,000 students submitted posters on the general theme of alcohol use. A total of seven winning posters were chosen by the ARF's Michael Goodstadt, Donald Murray, and Henry Schankula. The winners will receive a $100 savings bond and the satisfaction of seeing their posters printed (in quantities of 12,000 each, to be sent to the schools). Two T-shirt designs were selected — "Alcohol Bugs Me" and "Start a Trend" — and 140 participants whose posters made it to the finals will receive certificates of honorable mention. Below are six of the winning posters. The artists are: 1. Sheila Greenland, 14, Herron Valley Jr. High, Toronto; 2. Susan Thurow, 10, Appian Public School, Willowdale; 3. Allan Stauch, 17, Alternative Scarborough Education; 4. Christine Glazier, 15, Bramalea Secondary School; 5. Sheila Greenland; 6. Eric R. Hargreaves, 10, Oriole Park School, Toronto.



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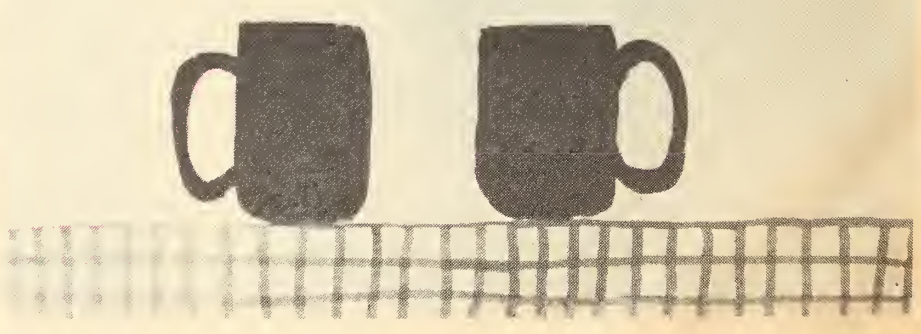

6.

Patricia Harris

Joe Califano

HUD's Harris heads HEW

By Harvey McConnell

WASHINGTON — Anti-smoking drives by the United States department of Health, Education, and Welfare will remain as vigorous as ever, according to Patricia Harris, who has been appointed and confirmed by the Senate, to succeed ousted Joseph Califano as HEW Secretary.

Ms Harris, who had been director of the department of Housing and Urban Development until President Jimmy Carter's wide-ranging cabinet reshuffle, said she was a long time friend and colleague of Mr Califano's and "Nobody should take any comfort with my appointment in respect to my changing . . . policies."

Mr Califano, in his term of office, was a vigorous and abrasive campaigner against smoking, which he dubbed "Public Health Enemy Number One." He set up an office of Smoking and Health, and his stance won him the emnity of American tobacco farmers, which is one of the reasons for his downfall.

Lately, Mr Califano had taken a similar stance on alcohol's use and abuse. He called alcoholism, "treatable and beatable, and Public Health Enemy Number Two." He also took a direct hand in recent appointments of directors of the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Ms Harris, a long-time Washington lawyer, has been American ambassador to Luxembourg, a top member of the Democratic party machine, and on the board of directors of several corporations, including the Chase-Manhattan Bank.

She is known for being a hard worker, a blunt speaker, and ready to fight for her constituencies.

Abnormal bones, joints seen in FAS

By Betty Lou Lee

EDMONTON — Bone abnormalities in children with fetal alcohol syndrome, particularly cervical spine fusions, have been demonstrated in a study of 43 children at the University of British Columbia (UBC).

Thin bones in the last joint of the fingers, abnormal rib cages, and small skulls were also found in a significant number of the children.

The study confirms in humans what earlier work on mice with fetal alcohol syndrome at UBC showed in 1977.

Spine fusions

David F. Smith, associate professor of pediatrics at UBC, presented the survey results at the annual meeting here of the Canadian Paediatric Society. (He is not the Dr David Smith of Seattle, Wash. who coined the term fetal alcohol syndrome in 1973).

The cervical spine fusions were seen in 16 of 36 children whose spines were x-rayed at a variety of levels. While in most cases they didn't appear to affect the child's movements, one child had limited head motion because he had a single neck joint instead of seven. The C2, C3, and C4 vertebrae were fused, as were C5, C6, and C7.

Small skulls were noted in 20 of 39 children who underwent skull x-rays, which wasn't surprising since microcephaly is one of the characteristic features first noted in these children. Other facial characteristics are small eyes, short upturned nose, low hairline, long upper lip, and drooping eyelids.

Of the 42 children whose hands were x-rayed, 27 had a characteristic tapering of the last finger joint with a tufting at the end.

Eleven of 37 had an abnormal rib cage: pigeon or funnel chest, or rib abnormalities. Dr Smith said the narrowed chests might cause problems later because of pressure on the heart.

Abnormalities in the radius or ulna were seen in nine children. One had limited arm movements because these two bones were fused at the elbow.

Dr Smith said in an interview that the most useful application of the findings will be to confirm a clinical impression of fetal alcohol syndrome, possibly avoiding more expensive evaluations.

Other x-ray findings included congenital heart disease in 14 children.

Renal problems

A kidney study is just getting underway with these children, but abnormalities have been found in four of 14 children given intravenous pyelograms, which correlates with other clinical reports of renal problems.

Dr Smith said developmental delay and/or mental deficiency has been documented for all but one of the children. Nine have significantly delayed bone age. The IQs range from 65 to 101.

Most of the children's mothers were native Indian women, and while an accurate estimate of their alcohol consumption can't be made retrospectively, "all were extremely heavy drinkers, not just two-a-day."

They were not only weekend binge drinkers, but had a daily intake of about five drinks of beer, wine, or liquor.

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The Journal

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Feds, BC clash on heroin program

By Jeff Carruthers

OTTAWA — The federal government continues to stave off demands from the government of British Columbia for financial support for that province's controversial mandatory heroin treatment program.

Unchanged to date is the long-standing federal view that Ottawa is already providing BC with indirect funds to its health care contributions which could be used for such drug treatment.

In addition, federal bureaucrats are now balking at any decision until the legality of the heroin treatment program can be determined in court cases already under way.

Senior federal officials strongly suspect the BC program will be struck down as an unconstitutional infringement of personal rights.

Meanwhile, the much flaunted changes to Canada's marijuana and hashish laws are not high enough on the priority list of the new federal Conservative government to be scheduled for review at the late August policy sessions of cabinet in Jasper, Alberta.

That western cabinet meeting will determine the principal policy thrusts of the minority Conservative government when parliament resumes on October 9.

While bureaucrats in other government areas are scrambling to have new policies ready for review at Jasper by the end of the month, the health department has been given no such deadline for the cannabis law changes.

The possibility of a further crackdown on amphetamines now seems to have evaporated forever. In the last days of the Liberal government, tighter controls on these drugs were being urged by Justice department officials.

Good news on secret drug files?

By Jeff Carruthers

OTTAWA — There is potentially good news for the thousands of Canadians with "drug records" being kept in the bowels of the federal Bureau of Dangerous Drugs.

Senior federal health department officials are in the midst of a major review of the need, if any, for the controversial drug files, in light of duplication of the files by RCMP (Royal Canadian Mounted Police) and local police and in light of the files' possible infringements of personal rights.

The officials would not discuss the review until the departmental decision can be made later in the summer. But, it is known that both the "type and kind of information" to be kept in the department's drug files in future are being considered with a view to change.

As important, the officials are studying the length of time the records should be kept and the manner in which information can be destroyed.

Behind the review is the growing realization that the information, especially personal information, may not be as vital as more junior officials had believed.

This has become apparent as a result of questions raised by the drug files in wake of the new Human Rights Act, which allows a Canadian to see what is in his or her government file.

The drug files in question cover several hundred thousand Canadians who are known or suspected to use illicit drugs. The vast majority, more than 190,000, cover known or suspected users of the cannabis drugs, marijuana and hashish.

Officials in charge of the files had claimed the information was needed for two purposes: to provide the basis for statistics on drug use patterns for reports to the United Nations; and to provide information for the health minister to decide on the disposition of money and other items seized in connection with drug crimes.

In a related matter, health department officials have agreed to tighten up, when possible, controls on who can receive information from health department drug files.

However, after a meeting with federal Privacy Commissioner Inger Hansen, the department decided against requiring fingerprints as proof of identity or requiring files to be collected at local police stations, in the belief that either of these could end up being a greater violation to personal freedom than not having such controls.

The meeting followed reports in The Journal that personal information from the drug files data bank was being mailed to individuals without requiring positive proof of identity.

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NEWS

Narcotics use in Britain rises steeply

By Alan Massam

LONDON — Home Office figures show addiction to narcotic drugs in Britain is rising steeply.

There were 2,408 addicts treated in 1978, a 19% increase over 1977, and a 22% increase to 1,352 in the number of new addicts in 1978. There was a 21% increase in renotified addicts.

At the same time, there were 13,400 controlled drug seizures, the highest ever figure since the Misuse of Drugs Act was introduced. Twice as much heroin, 60.8 kilograms, was seized in 1978 as in 1977.

The Home Office admits there is cause for concern. But, the Standing Committee on Drug Abuse (SCODA) representing voluntary bodies, is demanding immediate investigation.

David Turner of SCODA says the rate of increase suggests epidemic heroin addiction is on its way.

There are now three times as many addicts in the UK as there were in the 1960s, yet the complacency of Home Office and health officials is "incredible," he says. The Home Office is still claiming everything is under control, he adds.

British experts say don't legalize pot

By Alan Massam

LONDON — The council of experts set up to advise the British government on the misuse of drugs has decided cannabis use should not be legalized.

They say in a report* that a deterrent to the use of both cannabis and cannabis resin is still required. And any measure even to decriminalize on the patterns adopted by some states in the United States cannot, therefore, be recommended.

The report from the Advisory Council on the Misuse of Drugs, does, however, accept that the penalties for possession or trafficking of pot should be reduced by transferring the drug from a Class B to a Class C category as defined in the Misuse of Drugs Act.

This means the penalty for summary conviction for the possession of cannabis would be cut from a fine of £500 and three months in prison, or both, to a fine of £200 and three months in prison, or both.

On summary conviction for trafficking cannabis, the penalty would be reduced from six months or £1,000, or both, to three months or £500, or both.

The council says the recommendation that the drug should be transferred to Class C from Class B was passed by a majority of 21 to 6. But it urges that the United Kingdom continue to pursue "with the utmost vigor" the aims of the United Nations Single Convention on Narcotic Drugs. (ie that certain drugs including cannabis and cannabis resin should be used only for legitimate medical and research purposes.)

The government here has not yet made any move to accept or reject the council's proposals although it is widely expected to accept. Cannabis is the most widely used illegal drug in Britain. It is estimated, for example, that at least five million people have committed criminal offences by trying it.

A campaign to legalize cannabis was launched in Britain in June of last year.

Medical opinion on the possible adverse consequences of smoking pot is hotly disputed. A spokesman for the Legalise Cannabis Campaign said the council report was regarded as "hopelessly inadequate." The proposed reduction in penalties for smoking or trafficking the drug would have no effect since the recommendations matched the penalties currently given.

This view is disputed by several leading pharmacologists here, including Professor William Paton of the University of Oxford. He believes the smoking of pot could lead to deformities in the fetus and suggests all pregnant women should avoid it entirely. Although the view is based on animal experiments, he says, the possibility of risk in the human is real.

**Report on a Review of the Classification of Controlled Drugs and of Penalties under Schedules 2 and 4 of the Misuse of Drugs Act 1971. Home Office, 50, Queen Anne's Gate, London SW1H9AT. £1.75p.*

Attackers at large

TORONTO — Police in Berkeley, California, are still searching for the attackers of the prominent psychiatrist and polydrug abuse researcher Donald Wesson, his wife, and their two young children.

The family was attacked early one morning in late April (The Journal, June) when masked and camouflaged attackers entered their home and beat and stabbed the family as they slept.

The family was treated in hospital; Dr Wesson and his wife underwent surgery to repair head wounds. All members of the family are now out of hospital and Dr Wesson is back at work.

Local newspapers have published composite drawing released by police of one of the attackers.

Friends and associates of Dr Wesson have established a reward fund of $2,000 for information leading to the arrest and conviction of the attackers. Additional donations may be mailed to the Donald R. Wesson Reward Fund, 409 Clayton St, San Francisco, Ca, 94117.

Anti-psychotic cuts suicide

By Betty Lou Lee

TORONTO — The first placebo-controlled trial of prophylactic drug use among repeated suicide attempters has shown a highly significant improvement.

The drug is flupenthixol decanoate, given in injected depot doses, a neuroleptic usually used as an anti-psychotic in schizoprenia. Yet the suicidal subjects in the study were only patients who had no underlying diagnosis of depression, mania, or schizophrenia.

It has not yet been approved in Canada, although four groups in this country are conducting clinical trials of its effectiveness as an anti-psychotic.

The study results were reported by Stuart Montgomery of the Academic Department of Psychiatry, Guy's Hospital Medical School, London, England, at the annual meeting of the Canadian Medical Association.

Fourteen patients who had made at least two suicide attempts were given monthly injections of the drug, 20 mgs intramuscularly, for six months. A matched group of 16 was given water injections in the double blind study. Ages ranged from 18 to 68 years, with a mean of 35.

At the end of six months, only three, or 21% of the study group had made a suicide attempt, and 12, or 75% of the control group had.

The three failures in the study group made 15 attempts during the six months, and the 12 in the control group made 54.

Dr Montgomery stressed that the numbers were small and additional research must be done, but he considered the results "highly significant" since until now the half of repeated suicide attempters who are not diagnosed as having schizophrenia or affective disorders have had no specific effective treatment.

He said just because an anti-psychotic seemed to be effective didn't mean the patients were, in fact, undiagnosed psychotics. As a group, repeated suicide attempters tend to be irritable, hostile, and impulsive, and although there was some improvement in these characteristics in the treatment group, it wasn't significant.

Alcohol makes uneasy riders

OTTAWA — The danger that motorcycle riders' skills deteriorate more readily at lower alcohol consumption levels than those of drivers of four wheel vehicles, remains a "distinct possibility" following a study of 214 motorcycle fatalities by the Traffic Injury Research Foundation.

At the same time, the study appears to contradict earlier suggestions that young, drinking motorcycle operators were more likely to be involved in fatal accidents than older, drinking drivers. In fact, in this study, victims under 20 were found to have been drinking less often than those more than 20.

This finding focuses more attention on the effects on motorcycle driving skills of blood alcohol levels significantly lower than the legal 0.08% limit established on the basis of operators of automobiles. While the majority of motorcycle fatality victims under 20 years of age had not been drinking, 40% of the 20 to 24-year-olds were legally drunk, and a further 14% had been drinking.

In the 25 to 29 age group, 35% were impaired and 13% had been drinking but were not legally impaired.

The interesting phenomenon is that the percentage of motorcycle accident victims of all age groups who had been drinking but were not actually drunk, that is 12.6%, is about twice the percentage of victims who were drivers of trucks or vans and who had low blood alcohol levels.

It leaves open the "distinct possibility that the skills required to operate a motorcycle may deteriorate more readily at low blood alcohol levels" than those required to operate cars and trucks.

America will get its fix – if it takes the 82nd

By Wayne Howell

It appeared to bé an ordinary American morning. The sun rose pink-red, as it always does in urban American skies. The freeways slowly filled up with automobiles; the byways slowly filled up with recreational vehicles; the deserts filled up with dune buggies; the badlands filled up with all-terrain vehicles; the lakes filled up with outboards; the bays filled up with inboards; and the skies filled up with executive jets.

But this was no ordinary morning. There were rumors in the air. Unsettling rumors. Unspeakable rumors. A religious fanatic had seized control of a producing nation and production was at a standstill. A cartel of producers — Middle Eastern, African, Asian, and Latin American — had raised the price of the good stuff to unacceptable levels. And there wasn't enough domestic to go around.

The first people to hear the rumors were the dealers. Being prudent men, and well aware of the kind of violence withdrawal might lead to, they armed themselves with sidearms to protect themselves from their regular clients.

By noon the heavy users had become frantic. Long lines appeared in front of the dealers' establishments. Tension filled the air, and before long blood was being spilled in the lines. An arbitrary decision was made: users would be served on alternate days only. More blood was spilled.

Withdrawal triggered paranoid fantasies. Some said the big dealers were in cahoots with the producers; others said the big dealers were holding the good stuff offshore to drive up the price.

By mid-afternoon, many a Winnebago owner was nauseated with dread, many a V-8 owner was sniffling openly. The owners of big Harleys were even more irritable than usual. Van owners retreated into their mobile padded cells where they could do themselves no harm. Four-wheel-drivers huddled in small groups and wept openly. Private airplane owners fantasized about a hit of good Mexican, and snowmobile owners hallucinated about pipelines of potent Arctic snaking magically across the Canadian wilderness. Trembling inboard owners tried to calm their nerves with drinks on the afterdeck. Truck owners took to the streets with rifles and fired on their own kind. Waves of hysteria washed over America.

Fortunately for America, paranoia followed its usual pattern: by late afternoon the delusions of persecution had given way to delusions of grandeur. New rumors appeared. You could cut the good stuff with alcohol and still get a four-on-the-floor high. You could even make the good stuff with coal. The sun itself would save America and satisfy its awful craving.

And so, it appeared to be an ordinary American evening. The sun sank grey-red, as it always does in urban American skies. The freeways slowly emptied of automobiles; the byways emptied of recreational vehicles; the deserts emptied of dune buggies; the lakes emptied of outboards; and the skies emptied of private airplanes. A peace descended over the land. America would get its fix from new technologies. And if that didn't work, well, there was always the 82nd Airborne Division to make the producers listen to reason . . . . .

(Wayne Howell is an Ottawa physician and freelance writer.)

Women's drug/alcohol risks on rise

By Betty Lou Lee

TORONTO — More young Canadian women than men are now using alcohol, and doctors are also prescribing more central nervous system drugs for them than for adolescent boys.

Maureen Law, assistant deputy minister of Health and Welfare Canada, says the use of prescribed analgesics and tranquillizers is "potentially problematic" for the average teenaged girl because she is also likely experimenting with alcohol and is, at the same time, susceptible to hormonal changes and the inadequate nourishment that accompanies dieting.

Dr Law was taking part in a panel discussion of preventable problems in the female adolescent, presented by the Federation of Medical Women of Canada at the annual meeting of the Canadian Medical Association.

Drawing on data from a number of Canadian surveys, she said that by 1976, 90% of women 18 and 19 were alcohol users, compared to 88% of males the same age. In the 15 to 17 age group, it was 60% for girls, 69% for boys.

Tobacco use among girls 15 to 19 jumped from 18.7% in 1965 to 27.4% in 1975, an overall rise of almost 9%. In the same period, tobacco use dropped 5.5% from 35% to 29.5% in the same age group of boys.

There are wide regional variations for both alcohol and tobacco use. Of girls aged 15 to 17 in Ontario, 49% use alcohol; in Quebec, 75% do. Ontario users report drinking more frequently than Alberta users.

Dr Law said more girls are drinking, and drinkers are drinking more, for probably the same reasons as adults. One survey of almost 3,000 Ontario high school students of both sexes turned up only 5% who said they drank because of family problems, and 4% who cited worry or nervousness about school work.

More than half said they drank because they liked the taste; 30% because it cheered them up or made them feel good; and 18% because it helped them to relax. Fourteen per cent drank because their friends did, and 13% to get along better with the opposite sex.

Dr Law said the Ontario finding that women were prescribed psychotropic drugs twice as often as men seems to be borne out for adolescents too, according to data from Saskatchewan's prescription drug plan.

"This variance cannot be accounted for by frequency of visits to physicians ..... (it) is related to patterns of 'help-seeking behavior.' Women rely on health services, seek and utilize the services of professionals in ways not documented among men. Such behavior has been referred to as 'learned helplessness.'

"At the same time, women are more open about discussing emotional concerns, hence physicians are more apt to prescribe psychotropic drugs to women, including adolescent girls."

In addition to possible problems in mixing these drugs with alcohol, Dr Law said there are recent indications that women who use birth control pills remain intoxicated longer than those who don't. "These differences in ethanol metabolism are likely related to interaction between estrogen and monoamine oxidase activity."

She said the physician interacting with adolescent girls should keep in mind that they may be more comfortable confiding in a doctor who has not known them in childhood; they may associate drug use with adulthood and resent inquiries into this part of their personal lives; and they may be protective about a home situation where drugs are a problem for others in the family.

The girl may also have had her first sexual experience while she was under the influence of alcohol, or she may have been assaulted by a friend, stranger, or relative who was under the influence.

She may believe she'll gain weight if she gives up cigarettes, and she is unlikely to be aware of the hazards alcohol and tobacco present in pregnancy.

Dr Law said the present federal government focus in respect to drug use is on promotional strategies aimed at increasing knowledge and awareness among individuals, the community, and professionals. Women as a group are being given particular focus, with pamphlets like Women and Addiction; Pregnancy, Smoking, Alcohol and Drugs; and Contraceptive Pills and Smoking. There is also a national resource kit on women and addiction designed as a teaching guide for those working in addiction.

Women smoking in labor are smoking for two

By Betty Lou Lee

EDMONTON — One cigarette for mother equals two for the fetus in terms of carbon monoxide in the blood.

And when a mother smokes during labor, the baby's carboxyhemoglobin at birth can be two to three times the normal range, enough for chronic hypoxia (deficiency of oxygen in inhaled air).

"Mothers shouldn't be allowed to smoke in the labor room, or five hours before giving birth," Claude Pare, professor of pediatrics at the University of Sherbrooke, concluded after a study of 400 pregnant smokers and non smokers. He found that "an astonishing" one-third of the smokers in the study did so.

He presented his results at the annual meeting of the Canadian Paediatric Society.

The study measured the percentage of carboxyhemoglobin in the mother's blood at the beginning and end of pregnancy, and at delivery. The baby's cord blood was measured at birth. There was no attempt to correlate the readings with clinical findings in the babies, such as Apgar scores or respiratory problems.

About one-third of the mothers in the study at the University Health Centre were smokers, but the habit was more common among the younger women. Nine of the 15 women aged 20 or younger smoked, as did 41 of the 96 who were aged 20 to 25. Only 11 of the 74 mothers 30 to 35 years old smoked, and one of the 18 more than 35 years.

"These data suggest that the public health program should direct its publicity towards the mothers who are less than 30 years of age. The number of mothers aged 20 or less is small, but nevertheless in a few years they will be in the age group where we have the greatest number of pregnancies," Dr Pare said.

Non smoking mothers had .4% carboxyhemoglobin at the beginning and end of pregnancy, and their babies were born with 4.4%.

In smoking mothers, it was 3.4% at the start of pregnancy and 2.9% in the blood sample taken on admission for delivery, "not a very convenient time to have a cigarette". Their babies were born with an average of 6%, which rose to 9% if they smoked during labor — double the level of the control group. Three babies whose mothers smoked during labor had a level of 14%, which "we think is enough to compromise the normal physiology of oxygen transport and cause chronic hypoxia in the fetus."

Dr Pare said the affinity for carbon monoxide is not only higher for fetal blood than maternal, but its half-life is longer in the fetus. "The toxic effect for the fetus follows the equation: one cigarette for the mother, two for the fetus."

Honesty can temper staff burn-out

KING OF PRUSSIA, PA — Administrators of drug and alcohol programs must be honest with counsellors not holding college degrees by giving a realistic appraisal of their chances of promotion.

If they do not, they are being unethical and promoting "burnout" among staff, according to Gary Jensen, executive director of the Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Mr Jensen, who put his views at the annual Eagleville conference, which focused on ethical issues in substance abuse treatment, told **The Journal**: "You have got to be up front with your employees, or you are promoting staff burnout.

"One of the problems we have in the drug and alcohol field is a blend of professional and non-degree counsellors, whom I still consider professionals, but they don't have a union card. In the early days a recovered alcoholic or addict had an opportunity to move up the ladder to a fairly high position."

Today, those without degrees come into a program at a level where their salaries are less than those with degrees. They must be told what they have to do to rise in the ranks, such as becoming accredited, and not given false expectations of future promotions.

Mr Jansen said he meets with the 140 members of his staff at least once a month, "where we sit down in open sessions to bring them up to date and give them an opportunity to deal with any problems."

At least once a year, he takes his middle management level staff on a three day retreat, "where we don't necessarily have to play our roles and are equal, because if you play your roles too hard then things can begin to fragment around you."

Teen's single alcohol binge —multi-drug use measure?

WASHINGTON — The best predictor of multiple drug use among young people is to find out their maximum alcohol intake in one session, research at the University of Washington has shown.

Elizabeth Morrisey, of the university's alcohol and drug abuse institute, said the findings are based on 1,470 adolescents, 857 of whom were referred for alcohol related offences.

Ms Morrisey told **The Journal**: "We found that the best predictor of multiple drug use is the measurement of their maximum alcohol intake in one session and not an average, or a range, of their drinking. It is quantity and not duration.

"If a young person is asked how much he or she drank on one occasion in the last month, and the answer is, say, 10 or more drinks, then for sure they are multiple drug users."

She and her colleagues found that young people involved in multiple drug use turned to marijuana and amphetamines in the majority of cases.

BABIES WEIGH LESS

Smoking moms eat more

EDMONTON — Babies born to smokers usually weigh less than those of non smoking mothers, and many people gain weight when they stop smoking.

So a group from the University of Manitoba set out to find if the lower birth weight could be accounted for by smoking mothers eating less during their pregnancies.

They found they ate more.

James Haworth, professor of pediatrics, reported on the study at the annual meeting of the Canadian Paediatric Society.

It involved 94 smokers and 59 non smokers in a low socio-economic group, and 208 smokers and 175 non smokers of high socio-economic status, with incomes about double the first group.

The mothers in the lower group gained 12 kilos during pregnancy and in the higher, about 13 kilos, and there was no difference between smokers and non smokers in each group. But in the lower group, the babies weighed about 216 grams less when smokers were compared to non smokers, and in the higher group, 224 grams less.

Not only did the smokers average more daily calories, 2,587 compared to 2,421, but their fat intake of 118 grams was significantly higher than the 104 of non smokers.

The only thing the smokers consumed less of was Vitamin C.

"We conclude that fetal growth retardation due to smoking is not caused by diminished food intake by the mother," said Dr Hawarth. "There has been a lot of speculation about the many products of tobacco smoke that go into the fetal circulation, such as nicotine and carbon monoxide. But there is also the suggestion that it is the person who smokes, rather than the smoking, that's the important factor, because smokers and non smokers are different kinds of people. Smokers drink more alcohol and coffee, for example."

Drinking more coffee with cream and sugar could account for the higher calorie and fat intake of the smoking mothers, he noted. If they drank coffee instead of fruit juice, it might also account for their lower Vitamin C intake.

NEWS

Few patients need narcotic cough medicines

CMA asks for broader health plan coverage

By Betty Lou Lee

TORONTO — Canadian doctors want provincial drug benefit plans to reimburse patients for cough preparations that do not contain narcotics, as well as for those that do.

The Canadian Medical Association's general council, responding to a 25% increase in the use of both licit and illicit narcotics since 1971, voted at its annual meeting to encourage such coverage.

It will also ask the Health Protection Branch and provincial pharmacy authorities to require written prescriptions for all products containing hydrocodone and oxycodone. This would apply to refills of prescriptions as well as new ones.

Canadians are now the world's leading users of hydrocodone, and are second in use of oxycodone.

In its report to CMA council, the council on medical services noted that cough preparations containing narcotics require a prescription in all provinces, while the non-narcotic ones don't, and aren't usually covered by drug plans.

"Physicians are naturally encouraged to prescribe narcotic cough preparations to those patients eligible for drug benefit plans. It is a widely held opinion among specialists, and it was the unamimous opinion of the subcommittee of pharmacotherapy, that dextromethorphan is generally a satisfactory cough suppressant, and that only a very small number of patients ever require the use of narcotic cough suppressants."

It added that many doctors are unaware of the abuse potential and addictive properties of many cough preparations, and should be reminded of them.

The report also noted that increasing effectiveness in suppressing the illicit narcotic market has resulted in more pressure on the licit one: break-ins, holdups, and prescription forgeries.

"Certain marketing techniques may be responsible for some of the problems. These include introduction of impressive quantities of samples which are handed over to physicians ... Some manufacturers are particularly aggressive in distributing samples of either new or well-established products that contain codeine or other narcotics.

"Some cough preparations that contain hydrocodone and oxycodone have become so popular that pharmacies must stock large quantities, making them highly susceptible to break and enter.

"The free market type of economy in Canada results in a saturation of the market with large numbers of almost identical products by different manufacturers. It is felt that the proliferation of these drugs and the aggressive marketing techniques in promoting their sale result in increased consumption."

Yedy Israel: in some cases, PTU has doubled rate of recovery from alcoholic hepatitis.

Reports on PTU, the Pill, methadone

By Tim Padmore

VANCOUVER — More than 1,000 medical researchers and biologists reported basic research findings at the annual meeting here recently of the Canadian Federation of Biological Societies.

Among highlights for addictions researchers:

Yedy Israel, director of the clinical institute of the Addiction Research Foundation of Ontario, was awarded the Upjohn Canada award for his work on a drug that protects the liver against damage from alcohol.

The drug, propylthiouracil (PTU), has doubled the rate of recovery from alcoholic hepatitis in 150 patients studied at four Toronto hospitals. It's estimated that in three years the drug will save the dollar cost of all the research done over the 28-year history of the foundation.

PTU moderates the voracious demand for oxygen of alcohol-burning liver cells, a demand which leads to other liver cells being oxygen-starved.

At the meeting Dr Israel and his associates reported further work on the mechanism of action of PTU that could lead to the development of still more effective compounds.

PTU was discovered during the 1940s and used to treat hyperthyroidism.

So the researchers looked at two related drugs that, like PTU, are active against hyperthyroidism but, by distinct mechanisms: one blocks thyroid hormone synthesis and one blocks the breakdown of a thyroid hormone.

Tested on rats, only the first drug, methimazole, lent ethanol protection.

Since PTU works the same way as methimazole does, the researchers are fairly confident the ethanol protection is closely related to the action of synthesis blocking, an important guide to creating more effective compounds.

* * *

The Pill isn't all bad.

One bonus it apparently offers (to rats anyway) is protection against the effects of alcohol.

Betty Warren and Gail Bellward, pharmacologists at the University of British Columbia, reported that rats fed oral contraceptives and alcohol showed fewer fatty changes in the liver than expected. The pill also seemed to protect against the alcohol-induced lowering of BPH, an enzyme that breaks down the cancer-causing chemical, benzpyrene.

The result, Ms Warren said, was a surprise, since the reason for the experiment was to explore a possible connection between the Pill and liver cancer.

* * *

Methadone levels in the brains of infant rats were nearly as high as in the brains of their methadone treated mothers, McGill University researchers reported.

Raphael Pak said the drug, administered for two days to the mothers before the animals were sacrificed, is transferred with surprising efficiency through the placenta and in breast milk.

The drug levels stayed high for a week or more and were associated with changes in liver metabolism that may explain the high levels of protein in the urine of many of the 3,000 infants born each year to methadone addicted mothers.

Rx maintenance best tool against addiction: Tennant

PHILADELPHIA — Prescription drug maintenance is the only way a majority of people can be weaned off their drug habits.

Studies over the past three years with a number of middle class men and women have shown "we are going to have to bite the bullet and maintain them on their barbiturates, Valium, or amphetamines in reduced dosages," according to Forest Tennant, of West Covina, California.

Dr Tennant, in conjunction with the University of California at Los Angeles Center for Health Services, has employed counselling, medical withdrawal, and medical maintenance in a continuing program. All of the patients abused one or more prescribed drugs, volunteered for treatment, and were not in trouble with the law.

Dr Tennant said only 30% of the 46 patients in the first study reported abstinence 90 days after entering treatment. "We are getting much better results today, but it is a hard job," Dr Tennant told **The Journal**.

In his first study, reported at the annual scientific meeting here of the Committee on Problems of Drug Dependence, barbiturates, amphetamines, and diazepam were the most commonly abused drugs by the 25 men and 21 women patients.

Forest Tennant

'We can give better counselling...'

Despite a concerted campaign by a five-member clinic team, 22 patients left treatment and relapsed within one month, and eight relapsed between one and three months after entering treatment.

Only 13 patients reported they were abstinent from the drugs 90 days after entering treatment.

Dr Tennant said that while their results are better now, it is a long-term project. "We are now able to give better counselling, and we know we have to maintain them for a period of time if necessary.

"To be honest, even though a lot of people think addiction to barbiturates or diazepam is a horrible thing, I would rather have patients addicted to these than to alcohol or heroin. At least we have a success rate now which is higher than it would be for alcoholics."

Dr Tennant pointed out that all of the patients in the program sought help voluntarily, most are middle-class with middle-class values and jobs, "and they want legitimate treatment.

"In most cases, these people want to pay for their treatment and, in fact, expect to pay, as they do not feel they are getting anything unless they do so."

Dr Tennant: "We find now we are having around a 75% success rate in either getting people to switch drugs or to withdraw altogether. But we recognize also that there are a certain number of these patients that we are going to have to be prepared to maintain forever.

"Don't forget, this could be called a 'Cadillac model' of a multidisciplinary team and with considerable clinical resources. So, when we talk about prescription drug abuse we are just going to have to be realistic about the number of patients you can never get off some kind of drug."

'Teen bulge' twists mishaps rate

MADISON, Wis. — Rates of automobile accidents involving drunk teenage drivers is more a reflection of America's 18-year-old "bulge" than an actual percentage increase in accidents.

This is the experience in Wisconsin where the Bureau of Alcohol and Other Drug Abuse carried out a state study of youth, alcohol, and the law from 1933 to 1978.

David Joranson, chief of the program policy section, told **The Journal**: "We found there is no relationship between where the drinking age is set and alcohol abuse."

The legal drinking age in Wisconsin was lowered to 18 in 1972 and there is no evidence of any change in the rate, rate of increase, or rate of alcohol-involvement in highway crashes.

Mr. Joranson pointed out: "When we talk about statistics on teenagers drinking and being involved in highway crashes, we must remember that in 1979 there will never be more of an 18-year-old 'bulge' passing through the population and schools. If you were to say the problem is more visible because there are more kids of that age in school, you would be right.

"However, whether this means there is any per capita increase in these problems is an entirely different situation. National studies have shown that, regardless of where the drinking age is in a state, the age of first use is around 12.9 years."

The study concluded that raising the drinking age in Wisconsin is unlikely to prevent those who now drink illegally from continuing to obtain alcoholic beverages, and is unlikely to affect those who now disregard the law prohibiting sale or distribution to minors.

At the same time, raising the drinking age would probably increase the after-drinking miles driven and crashes involving those affected by raising the drinking age.

The study said a number of options could be considered:

- Warning labels, informing users of the maximum safe dosages and long term effect of misuse, may educate the public and help prevent abuse.
- Controlling and regulating advertising messages, audiences, and frequency may help reduce peer pressure and motivation to use alcohol.
- Reducing insurance premiums for moderate drinkers and abstainers may provide additional incentives to moderation and abstinence.
- Extending liability and increasing penalties for people who contribute to abuse by others may motivate parents, hosts, and friends to prevent abuse.
- Prohibiting alcohol sale, use, and barring the admission of intoxicated people to public buildings, parks, and sports arenas, may reduce the opportunity for consumption.

NEWS

Abstinence reduces cerebral atrophy —fast

'Significant recovery'

By John Shaughnessy

TORONTO — Abstinence makes the brain grow stronger — for chronic alcoholics.

If cerebral atrophy is included as the measure of brain damage, then it occurs in virtually all alcoholics, says Peter Carlen, head of neurology at the Addiction Research Foundation of Ontario (ARF) in Toronto.

But tests he conducted showed that in alcoholics with at least a 10-year history of drinking, cerebral atrophy was reduced a few weeks after the patients stopped drinking. At the same time, the patients showed improvement on neurological and neuropsychological tests.

Dr Carlen said the patients who recovered most were those who had a shorter time span between the last drink and first test. "So one would think the maximum amount of recovery occurs in the first three weeks."

In his lecture to the ARF's Clinical Institute, Dr Carlen said tests showed all but one of the 90 patients showed a decrease in cerebral atrophy, but in patients who were "questionably abstinent" there was less overall percentage decrease in the amount of atrophy.

The neurological tests were conducted at weekly intervals over a six week period. There was "tremendous variance" in the initial scores of the sample patients but, particularly over the first few weeks, there was a significant recovery of the score towards normal. The neuropsychological tests were conducted on average three to four weeks after the patient's last drink and a re-test was carried out about three months later. Dr Carlen said improvement was noted in verbal IQ, performance IQ, and memory quotient "especially among the patients whom we are fairly sure did not drink between the test and re-test."

Because of the difficulty in controlling the amount that human patients drink, Dr Carlen and his team are conducting animal studies to get at the basis of the partial reversibility of cerebral atrophy. His current hypothesis is that ethanol and/or its metabolites are neurotoxins, and these neurotoxins can impair protein synthesis. This impaired protein synthesis would cause cerebral atrophy and lead to cerebral dysfunction because of the decreased number of neurons and neuronal processes.

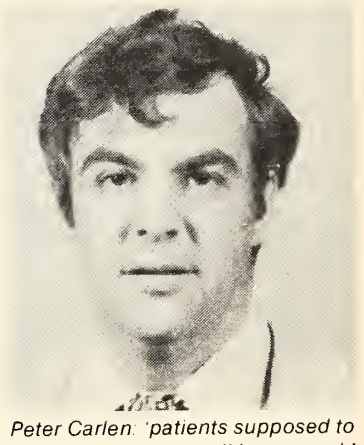
"One might recover if you take away the neurotoxin," said Dr Carlen. "You stop drinking and you permit increased CNS protein synthesis. Therefore, you get decreased cerebral atrophy . . . and you get functional improvement, although no one has reported neuronal replication. Some or all of the functional recovery from abstinence could be biochemical such as normalization of CSF acidosis."

The acidosis in the CSF could be of great metabolic significance in Dr Carlen's opinion. He measured the CSF pH in the alcoholics and found acidoses below 7.2. (The normal is 7.31 + .02)

"At that level, you're supposed to be comatose, yet our patients were up and walking around," said Dr Carlen. "They may have been a little knocked off, but they weren't nearly as bad as the literature indicates they should have been." Over the first few weeks after the cessation of drinking, the low CSF pH tended to revert to normal although there were some alcoholics whose level was still quite low many weeks after their last drink.

In earlier work, Dr Carlen looked at the amount of cerebral atrophy in his group of alcoholics. He found the alcoholics had significantly more atrophy than a group of neurologic controls who themselves are known to have a touch more atrophy than the general population.

"Because of our study group we really can't say how quickly brain damage develops (after the onset of drinking)," said Dr Carlen. "But we did find that the alcoholics tended to atrophy faster than the neurologic controls. The neurologic controls didn't develop any atrophy until after the age of 40 when the rate of development became fairly high. The opposite was true with the alcoholics. The atrophy rose much more quickly with age in the early years up to 40 and after that there was no significant increase."



Peter Carlen: 'patients supposed to be comatose were walking around.'

Low tar/nicotine cigarettes are looking safer in US

NEW YORK — Pre-cancerous abnormalities of the bronchial tree occur far less often in men who smoke low tar/low nicotine cigarettes than in those who smoke cigarettes high in tar and nicotine. And in non smoking males they do not occur at all.

These are the findings of an American Cancer Society study conducted by Dr Oscar Auerbach of the Veterans Administration Hospital in East Orange, New Jersey and Dr E. Cuyler Hammond and Lawrence Garfinkel of the American Cancer Society.

The researchers analyzed 24,475 tissue samples from 445 men who died of causes other than cancer during the years 1955-1960 and 1970-1977. They observed a decrease in occurrence of carcinoma *in situ* between the two time periods which they believe "should presage a decline in lung cancer death rates of cigarette smokers at some future date."

The study appears to reinforce earlier suggestions that cigarettes high in tar and nicotine are associated with higher death rates from lung cancer, said the society's president, Dr LaSalle D. Leffall, Jr. The findings may also explain why the nation's lung cancer death rate may have already begun to taper off in young males, he added. Among young females, however, the lung cancer death rate remains markedly on the increase.

Dr Leffall believes public demand for low tar/low nicotine cigarettes is a factor in the encouraging results of this study. However, "the nation's guard against cigarette health hazards must not be allowed to relax," he warned. "Because if it does relax, the good that has been accomplished will be undone."

He also cautioned that while the findings indicate smokers might reduce their lung cancer risk by switching to low tar/low nicotine brands, the best action is still not to smoke at all. "There is no such thing as a threshold of safety. There is no safe cigarette."

Most sleeping pill prescriptions are difficult to justify

WASHINGTON — Most of the prescriptions for sleeping pills written each year for an estimated 8.5 million Americans are not justified on medical grounds, according to a report by the National Academy of Sciences.

A study by the committee from the Academy's Institute of Medicine said that while sleeping pills have a place in clinical medicine and doctors have changed their prescribing patterns over the past eight years, it is still difficult to justify most current use.

'MDs should prescribe for only a few nights

In 1971, doctors wrote 41.7 million prescriptions for sleeping pills. By 1977 the number of prescriptions issued had dropped to 25.6 million.

There has also been a change in drugs prescribed: barbiturates, which were once a most popular compound, have been surpassed in popularity by benzodiazepines. Fifty-three per cent of all sleeping pills prescribed in 1977 were for flurazepam (Dalmane), a member of the benzodiazepine family.

The committee said the doctors should keep their prescriptions "to a very limited number of pills for use for a few nights at a time." In only rare instances should prescriptions be given for more than a two- to four-week supply of pills.

The beneficial effects of sleeping pills "is typically to reduce the time needed to fall asleep by 10 to 20 minutes and to lengthen the night's total sleep time by 20 to 40 minutes."

Doctors should warn patients about possible dangers from sleeping pills especially if used in conjunction with alcohol, the committee said. Patients should also be warned that some compounds linger in the body and after a period of use the patients run the risk of becoming too drowsy to drive a car or operate machinery in a safe manner.

The committee said the Food and Drug Administration should take steps to ensure doctors are given more information from manufacturers on possible side effects from sleeping pills. At the same time, doctors need to have better training in ways to treat those suffering from insomnia.

" We've come a long way baby! "

Cocaine can be fatal

MIAMI — Cocaine is far from being a safe recreational drug, according to Charles V. Wetli of the Dade County Medical Examiner's Office.

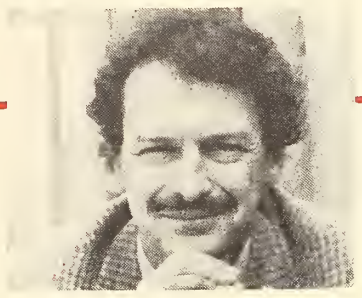
He reported on 68 deaths associated with so-called 'recreational' use of cocaine. Although 29 of the deaths involved concurrent use of other drugs, 24 were the direct result of the toxic effects of cocaine, he said.

Injection of the drug directly into a vein was found to be the most dangerous practice, causing respiratory collapse and rapid death. Although it takes somewhat longer, cocaine taken by mouth or sniffed through the nose may also result in respiratory collapse.

Dr Wetli said most of the victims had been using cocaine for its euphoric effects. However, three were smugglers who had swallowed up to 75 cocaine-filled condoms which ruptured inside their stomachs. Two others had swallowed cocaine when arrest seemed imminent.

"The toxic and potentially fatal consequences of cocaine were well known to pharmacologists and physicians during the first quarter of the century," Dr Wetli noted. "This report again demonstrates that cocaine cannot be regarded as a safe, recreational drug."

NEWS AND COMMENT



GILBERT

'We should consider ourselves fortunate that some of the victims of our collective drinking habits get together to help themselves . . .'

Views on Alcoholics Anonymous

By Richard Gilbert

Alcoholics Anonymous is not often covered in **The Journal** or, indeed, in any place where professionals in the alcohol field can be read, seen, or heard. Yet, according to a paper by sociologist Robert Tournier in the March 1979 issue of the *Journal of Studies on Alcohol*, AA "has come to dominate alcoholism both as an ideology and as a method" and AA's "assumptions about the nature of alcohol dependence have virtually been accepted as fact by most of those in the field."

THESIS

Tournier's thesis is that AA's "domination of the alcoholism treatment field . . . has fettered innovation, precluded early intervention, and tied us to a treatment strategy which, in addition to reaching only a small portion of problem drinkers, is limited in its applicability to the universe of alcoholics."

After noting that "it is impossible to establish accurately something as seemingly straightforward as the number of people reached by AA," Tournier suggested probable AA membership in the United States is near 500,000, or 5% of that country's alcoholics. The highest reported recovery rate due to AA is 67%, ie, 3.3% of all US alcoholics.

Tournier gave little substance to his argument that AA has fettered innovation. He alluded to false claims by AA about its effectiveness which, being believed, pre-empt experimentation. Tournier's figures themselves suggest much scope for innovation — among the 95% of alcoholics that AA does not reach.

Innovation for Tournier seems to mean controlled drinking which, for AA, is a "bête noire." The "revisionist view of alcoholism dependency," that "alcoholism . . . can be viewed as learned behavior . . . susceptible to . . . behavior modification techniques," has led to the view that some alcoholics can be taught to drink less without going so far as abstaining. Such proposals have met with "vilification" from AA members who see them as an attack on AA's ideological position that alcoholism is a unitary phenomenon, which they are. As even the revisionists seem to agree that controlled drinking is not a realistic objective for most alcoholics, the point hardly seems worth elaborating.

Tournier claimed that early intervention is inhibited by AA's message that an admission of powerlessness is a prerequisite to recovery. By requiring despair as a condition of recovery, he argued, AA denies help to those who are merely becoming desperate. But Tournier gave no evidence that such early intervention works, and it is not easy to see how he could. If AA is right, and recovery is helped by reaching what members call a "low bottom," unsuccessful early intervention might do no more than *retard* the possibility of effective treatment.

Not much was said by Tournier to the claim that AA has limited treatment strategies, except that AA has opposed controlled drinking as a legitimate goal of treatment. Since most alcoholics would appear to do well to abstain if they are unhappy about their drinking, and since AA rarely bothers scientists and clinicians who are working on better ways to get people to quit alcohol, Tournier's claim seems unfounded.

RESPONSES

In the same issue the *Journal of Studies on Alcohol* published seven responses to Tournier's paper, a useful practice, exercised superbly by at least one other journal, *Behavioral and Brain Sciences*.

Psychiatrist Donald Goodwin wrote, among other things: "I believe that Tournier has written a well-balanced and sophisticated evaluation of AA without diminishing by a jot what he and I both agree upon: AA does indeed work with many individuals where nothing else will." Goodwin expressed hope that "as an organization (to the extent it is an organization) . . . fanaticism and dogmatism would have little place," but noted that British psychiatrist D. L. Davies "actually had his life threatened when he found in a study [in 1962] that a few alcoholics seemed to manage their drinking with some degree of control."

Psychologists Linda and Mark Sobell have, according to Tournier, "borne the brunt of reaction to controlled drinking proposals." They argued that AA's influence has generated [US] federal support for alcoholism treatment services and that, paradoxically, "the knowledge derived from these activities can not be perceived as threatening the dominance, perhaps even the viability, of the AA organization." The Sobells concerned themselves with the question of how the viability of AA can be preserved. They conclude that "AA leaders and AA-allegiant treatment providers" must recognize that AA's "vital function" cannot continue if "other views and treatment alternatives" are excluded.

Anthropologist William Madsen wrote scathingly about Tournier's article, suggesting it is another example of the "sheer nonsense" social scientists frequently publish in the name of science. He wondered why Tournier wrote the article, and noted that Tournier could have summed up his thesis by saying: "Therapy for addiction is not necessarily the most appropriate approach for those who are not addicted," a thesis with which Madsen found himself in complete agreement.

Psychiatrist Robert Moore urged us "not to injure AA by demanding that it be a scientifically oriented organization." Chaim Rosenberg, head of Boston City Hospital's Alcohol Division, argued that "when Tournier criticizes AA for its doctrinal rigidity, he is really contrasting the scientific and the lay approaches to treatment," and that "it is still less than certain that professionalism and the scientific methods have improved the treatment of alcoholism beyond what self-help groups can achieve."

Social work professor Harold Demone reported unpublished data from a Boston survey indicating that most people say that AA would be their "assistance of choice" if they had an alcohol problem; but, most people who have an alcohol problem do not seek outside help and, of those that do, many more go to physicians, particularly psychiatrists, than to AA. Therefore, Demone argued, "AA has more effectively stimulated the imagination of the general public than of alcoholics."

Finally, Gerald Shulman argued that Tournier's position "would have been more appropriate 10 or 15 years ago." He made the point that stopping alcoholics' drinking is not the problem — "they 'stop' continuously . . . the problem for the alcoholic is not the bottle, but the belief in the bottle, or the belief in the magic of the chemicals." By this comment, Shulman seemed to be suggesting that AA's strength might lie in its ability to substitute one magical belief for another.

ARF VIEWS

To round off these comments, I solicited opinions on AA from scientists and clinicians at the Addiction Research Foundation of Ontario, all concerned with alcohol problems. One respondent requested anonymity because "the harassment involved is not worthwhile." I sympathized, having been harassed myself by an organization in the drug field. To ensure the respondent's anonymity, all of the following comments are anonymous:

"Although AA is justifiably praised for its pioneering role in the treatment of alcohol-related problems, it has evolved over the course of time into a reactionary organization which, at present, exercises a stultifying effect upon the field. In particular, its claim of universal therapeutic efficacy is patently false and its hysterical attacks upon alternative treatment philosophies wholly unwarranted."

"They give undue credence to the disease concept of alcoholism, but this is perhaps inevitable, given the difficulties involved in maintaining abstinence . . . AA is generally a wonderful organization, but I don't think they can be completely objective about many alcohol issues."

"AA has failed to retain many alcoholics as members partly because of its religious bias, but mainly because of its insistence that alcoholics are fundamentally different from you and me . . . AA's great contribution has been to show that self-help groups working in the community can be at least as effective as most expensive, hospital-based treatments."

"AA is one of the few movements that capitalizes on the powers of social pressure and social organization, which are the real controllers of people's behavior. It raises the question as to whether the one-on-one approach of typical medical and psychological intervention could ever be effective."

My own views? Our society drinks to the extent that it produces more people seeking help for their alcohol problems than it is prepared to cope with. We should consider ourselves fortunate that some of the victims of our collective drinking habits get together to try and help themselves. Whether or not they are successful seems largely irrelevant. Failure to achieve a cure for alcoholism has never deterred professional therapists, and there is no compelling reason why AA should be thwarted by allegations of inutility. As in much of medicine, it may be the treatment that counts, not the cure.

My only gripe about AA is the extent to which its participants are encouraged to drink coffee. AA conventions feature special plumbing arrangements to ensure a steady flow of the stuff. Most AA members appear to down enough coffee to pose a risk to their health, although rarely as much of a risk as from their previous alcohol use. Nevertheless, 10 strong cups a day — the typical consumption according to one report — can upset your stomach, disturb your sleep, palpitate your heart, shake your hands, and make you into a pretty anxious person.

Next month: Energy dependence — does science have a cure?

BMA condemns all tobacco advertising

LONDON — The British Medical Association (BMA) has given powerful backing to the growing demands here for a complete ban on all forms of tobacco advertising and tighter controls on advertising of alcoholic drinks.

Delegates decided by an overwhelming majority at its annual representative meeting in Liverpool that immediate approaches to this effect should be made to the government.

Later, observers at the meeting were saying the heavy vote in favor of the "anti addiction" motions reflected an unprecedented degree of British medical concern. The BMA had accepted that smoking was "the greatest threat to health amenable to preventive measures."

The government is to be asked to accept a seven-point plan of action to reduce the heavy toll of tobacco related diseases. These are:

- To forbid all forms of tobacco advertising (not only cigarette ads on TV which are already forbidden);
- To ban the sale of sweets in the shape of cigarettes;
- To discourage the provision of cigarettes as gifts or incentives by employers;
- To demand legislation for the printing of tar and nicotine content on all packets of cigarettes;
- To seek to increase the number of non smoking areas in public places;
- To ask National Health Service authorities to make separate provisions in hospitals for patients and staff who smoke;
- To urge the government to allow the price of cigarettes to rise.

The condemnation of tobacco advertising followed a speech by a well known anti-smoking campaigner, Keith Ball, who said the position in Britain in relation to tobacco advertising was "a positive disgrace."

Dr Ball, chairman of the Action on Smoking and Health (ASH) lobby group (sponsored by the Royal College of Physicians) said: "Tobacco advertising is sordid, tobacco kills and we have got to accept it.

He strongly supported the move to ban all rather than some forms of tobacco advertising because he claimed tobacco producers would find ways of avoiding anything but a total ban.

On the question of excessive alcohol consumption, Michael Illingworth told the meeting alcohol was a potentially dangerous drug which, if produced for the first time today, would be put in the same class as LSD.

The advertising of alcoholic drinks stressed that they were manly, sexy, or "with it," and there was a social disinclination to condemn those who misused them.

The meeting subsequently threw out a move to reduce the blood alcohol level at which motorists could legally drive from 0.08% to 0.04%.

Critics of the motion said the police were already having too much difficulty enforcing the present blood alcohol limits.

PROFILE

'Plan's public image its major problem'

The BC heroin plan won't go away: Altman

VANCOUVER — The future is uncertain for the British Columbia heroin treatment plan. But Jack Altman is as certain as he can be about one thing.

"There is a huge population out there which is going to require treatment. Whether the courts support the constitutional case or not isn't going to change that. There is going to be a heroin treatment program no matter what happens."

The court in question at the moment, is the Supreme Court of BC, which has been deliberating the merits of a constitutional challenge aimed at legislation that allows police to refer suspected drug addicts into the plan, even without evidence of commission of a crime.

Should the courts truncate the committal authority to eliminate police referrals it would hardly make any difference, he says.

The first director of British Columbia's compulsory heroin treatment program is 33-year-old psychologist, Jack Altman, formerly an academic researcher and director of a psychological consulting firm in Montreal.

Surrounded by unpacked boxes of books and periodicals in his new Vancouver office, Mr Altman talked to **The Journal** *about the controversial plan, the directions he hopes it will take and how he plans to guide it, and of drug abuse in general.*

Here is a report of that interview from our Vancouver correspondent Tim Padmore.

Jack Altman, director of BC's heroin plan. hopes to get the controversial program on the tracks.

'Tempest in teapot'

"My view of the program is that the large majority, 70%, 80% or more were never coming in on a police referral basis anyway. That's why I always thought (the opposition) was a tempest in a teapot."

Most will come through the courts, he says, either as an alternative to sentencing or even at an earlier stage in the court process.

As mid-year approached, the plan, which officially started January 1, had 65 addicts who have come in through the Heroin Teatment Act.

Of those, 15 to 20 are volunteers and the rest have come through the courts. No police referrals were scheduled before July and that date was in danger of slipping because of the unsettled court case.

Mr Altman is not surprised at the small number of volunteers. (The Alcohol and Drug Commission, which administers the plan, has variously estimated the heroin addict population in BC between 6,500 and 10,000.)

"I don't see a great number, after all the negative publicity, ready to volunteer for treatment right now."

The great hope is for the court referral system. The present trickle of clients from individual judges should swell to a flood when negotiations now under way with provincial and federal justice officials are completed, Mr Altman says.

The future, he predicts, should also bring a better public image.

"The major problem the heroin plan has gone through has been its public image. Gradually over the next two or three years people are going to realize it's not the fiendish thing they've been told.

"There are three factors: first, it's not going to go away, and while it's not always a good thing, permanence tends to generate credibility.

"Second, people are going to find the treatment we're offering is a very good one. And third, our staff is of a very, very high calibre."

Won't it help too if the police compulsion is dropped?

"Were the police referrals removed, it might make some difference to the acceptance of the program, but I personally don't think it would make much difference."

The most forceful opposition has been aimed at the police referrals with secondary targets being the three-year treatment term, the high cost (around $9 million this year, down from the $16 million originally allocated) and the style of treatment.

What makes it "a lot easier for people to get upset is that no one can promise the treatment will produce results.

"If we could say we could guarantee 100% success, the outcry would be very muted."

While there's no expectation of 100% success, there is a determination to document what success is achieved.

"Accountability. I think that is the main problem, not only in the drug abuse field, but the mental health field in general. The patients come and go and nobody is really trying to measure whether the patients are getting any better and even sometimes whether the counsellors are doing anything."

While counsellors will have great freedom to structure treatment in their own way, the program will be strict in four areas: clients will have to supply regular urine samples, keep appointments faithfully, maintain contact (usually by phone) with the clinic, and keep records of their activities.

"These four things will give us accountability. They're the essentials of a treatment program because they give us data."

Mr Altman says his research background may account for his determination to "know what is going on."

He lists 17 research publications starting when he was a masters student at the University of Western Ontario. PhD work in biopsychology at the University of Chicago came next, followed by junior faculty appointments at several universities, including Harvard Medical school.

Much of the work had to do with the effects on perception of drugs like LSD, amphetamines, THC, and chlorpromazine.

The work was relevant to his present job, he says.

"I really believe as a professional psychologist that a lot of things that control our behavior are environmental and that includes drug taking. You really can alter a person's perception of how they feel under a drug, or whether they are going to take a drug, by changing things in their environment. And the things you have to change in the environment may not actually be drug related events."

For example, changing something as simple as a man's hours of work can send drug use up or down — for example, if the job gives a lot of free time and there's a bar downstairs.

Many heroin addicts, he says, suffer from a sort of cultural deprivation. They start taking drugs at 15 or 16 years old and drop out.

"Instead of growing through those very difficult years, they've been involved in a system inconsistent with growth."

He drew an analogy with the lives of some amateur athletes.

"Quite often I feel athletes are exploited and used. It's most striking in the amateur field — skaters, swimmers, divers — putting in all that time . . . six to eight hours a day of practice.

"They don't have the time to spend on things other teenagers spend time in. When they're 19 or 20 they've missed certain things."

While "over-the-hill" athletes are not deficient in the way drug addicts are, they often suffer personal problems such as obesity and they face a similar need to restructure their lives.

"Any time you devote a lot of your life to one special thing, your life is going to suffer, including drugs . . .

"Drugs are also a biological time bomb. The lifestyle itself gives you a lot of risk — the unsanitary conditions, needles, the disease process, drugs cut with other drugs."

When addicts first come into the BC program, the first thing they're offered is a "crash survival system" to deal with acute problems like ill health or lack of housing.

Then comes an elaborate assessment to help find remedies for the drug abuser's particular deficiencies ("if we remove that drug crutch, we've got to have something to substitute.")

Counsellors will be the main actors in treatment teams that will also include a senior counsellor and "community support worker."

There will also be specialists in vocational guidance, assessment, and so forth, actually residing in treatment clinics.

Mr Altman, bearded, tieless, and informal, says it will do the specialists good to be in touch with the grassroots. He says he hasn't completely ruled out doing the same thing with his most senior deputies too.

'Program will boom'

He says the plan will try some things others haven't, such as developing special treatment procedures for females (an estimated 15% to 20% of the clientele).

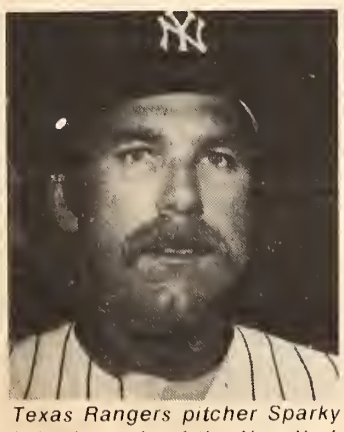
The facilities will also serve as a community resource. For example, the 150 bed residential treatment centre at Brannan Lake will continue to be used as a detox centre for non-narcotic drug abusers, and sophisticated urinalysis equipment may be made available to physicians who want to do tests on drug metabolism.

That would help soak up some of the unused capacity of the program, which has been designed to handle 2,500 addicts at a time.

But Mr Altman predicts the program is going to boom beyond current shrunken expectations when the court referral arrangements are sorted out.

"My opinion is that (the estimates of client flow) are going to have to be altered and we are going to have to go back to the treasury board and ask for a lot of the things they took away from us to be given back."

Tobacco stats to chew on



Texas Rangers pitcher Sparky Lyle, formerly of the New York Yankees, makes TV pitches for chewing tobacco.

TORONTO — Sparky Lyle, a pitcher for the Texas Rangers "plugs" it on television, where it's still allowed space, and more and more Americans are snuffing it and chewing it.

"It," of course, is smokeless tobacco — whether dry or moist snuff, or loose-leaf, plug, fine-cut, or twist chewing tobacco.

Figures from the United States Tobacco Institute, as reported in the *New York Times*, indicate retail sales in the category covering pipe tobacco, roll-your-own, and all other nonsmoking products, were up 27.3% in 1977.

Cigar sales during the same period showed a decline of 7.7%, while sales of cigarettes were up only 3.9% over the prior year.

Smoking impairs dust clearance

By Ellen Redd

CAMBRIDGE, MASS — Heavy smoking appears to impair the ability to clear dust from the lungs, and may explain the susceptibility of heavy smokers to toxic particles in the environment.

A team of researchers from the Massachusetts Institute of Technology (MIT), the Harvard University School of Public Health, and Tokyo Denki University in Japan, headed by David Cohen of MIT, studied dust clearance from the lungs of nine non smokers and three heavy smokers for one year. They used a magnetic dust called magnetite, which is harmless in small amounts, and can be traced in the body through the magnetic field it generates.

One year after initial inhalation of the dust, the investigators found that 50% of the magnetite remained in the lungs

Cigarettes and toxic particles

of the smokers, while only 10% remained in the non smokers' lungs.

Although these numbers are small, Dr Cohen's group could find no factors other than cigarette smoking which would account for the observed difference in dust clearance.

They also noted that impaired dust clearance might explain the findings of a 1968 epidemiological study, in which asbestos workers who smoked were found to have a 90-fold greater risk of death from lung cancer than those workers who did not smoke.

Smoking may enhance the effects of toxic substances in other ways, they added. For example, chemicals in cigarette smoke might act in conjunction with carcinogenic particles in the environment, or occupational dusts might act as a vehicle to carry carcinogenic substances in cigarette smoke into the lungs.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

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'Muggeridge suprised me on legalization'

I have just received the May issue of **The Journal**, which I have read with great interest. But I was surprised that Malcolm Muggeridge does not distinguish between legalize and decriminalize. Perhaps he is technically correct that all offences against the law are criminal. But not all offences carry a criminal record. I have supposed the term decriminalize means that an offence which formerly carried a criminal record no longer does so. Perhaps the term should be clarified.

Countless young people carry criminal records for marijuana offences. This could have a very depressing effect if it prejudices their opportunities to follow the career of their choice. Discouragement could heighten their desire to find solace in drugs or alcohol.

The very heavy penalties which are legally possible for marijuana offences have failed to discourage the use of the drug. People complain that if it were legalized or decriminalized more people would use it, but this happens anyway. The legal penalties simply add to the hazards of drug abuse, and fail to give the protection which they are intended to give. Similarly, when alcohol was prohibited in the United States, a Federal Council of Churches inquiry noted that there was more drinking by young people.

Penalties ensure that what is done will be done in secret, and, in the case of minors, without the knowledge of parents or teachers. Those who use the drug will enter into a precarious and hazardous relationship with the underworld who will ruthlessly dispose of informers.

Mr Muggeridge charges that those who want to decriminalize are planning something crooked. At least we did not create the black market. We have not forced heroin addicts to commit crimes to raise the money to pay the high price of illegal drugs. Those responsible for this situation are the people who suppose a moral problem can be solved by prison.

But the problem will not be solved this way. This way, we simply fill the prisons, alienate youth, and burden the police. The Le Dain Commission of Inquiry into the Non Medical Use of Drugs warned that the use of drugs could only be controlled in a police state. Now we want to increase police powers. This is inevitable because we have made them our conscience.

Proper use of law has to be understood. In an electronic age, we must use law to protect liberties, not to destroy them. If we prohibit smoking in a public place we protect the liberties of those who do not want to breathe tobacco fumes, but when we prohibit smoking in private, whether it be marijuana or tobacco, we ensure no one's privacy will be guaranteed. We all come under surveillance because we have surrendered our private lives to the police whether we are innocent, or guilty.

Drug abuse should be countered by reinforcing self respect, not destroying it. We need to develop an entirely new approach to drug abuse based upon an enhanced self image and personal responsibility. If we do not, our boast of democratic freedom is just so much hypocritical humbug.

Prohibition of drugs is sometimes justified on the grounds that this is necessary to protect young people. Ironically, it is with the young that prohibition is least effective. Perhaps it is because we treat adults as if they were children that the young rebel. Legal controls might provide better protection for youth than a covert black market, but legalization might prove to be too drastic a step for a society accustomed to strict prohibition. Decriminalization would provide an opportunity to adjust to a more relaxed atmosphere, assuming that my interpretation of the term is correct.

Henry Boston
Newboro, Ontario

Editor's note: The distinction between a once-criminal act that has been decriminalized and one that has been legalized lies mainly in the consequences that occur when a person commits the act. If a person commits an act that has been legalized, he or she is acting within the law and no action can be taken by the state to prevent or punish this activity. If a person commits an act that has been decriminalized, he or she is still acting outside the law and can be prevented from so acting by the state. However, since this activity has been decriminalized, the state can not deal with it in the same manner that it deals with criminal activity. In practice, this means punishment for the commission of a decriminalized act is much less than that for the commission of a crime. Perhaps more importantly, a person convicted of committing a decriminalized act does not get this conviction recorded as part of his or her criminal record.

The Journal welcomes Letters to the Editor. Letters, bearing the full name and address of sender, may be sent to: The Journal, 33 Russell Street, Toronto, Canada, M5S 2S1.

'TJ a must'

No one interested in keeping in touch with policy, treatment, and/or available research in the field, should be without a subscription to **The Journal**.

Although it is published in Canada, I get more information on United States policy from it, than from our publications. Thank you.

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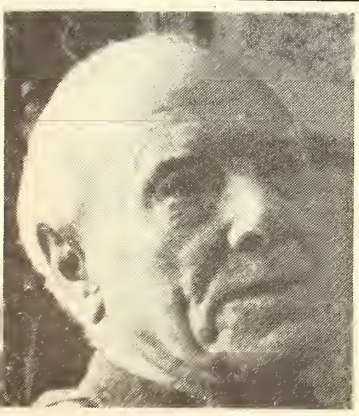
Chicago, Illinois

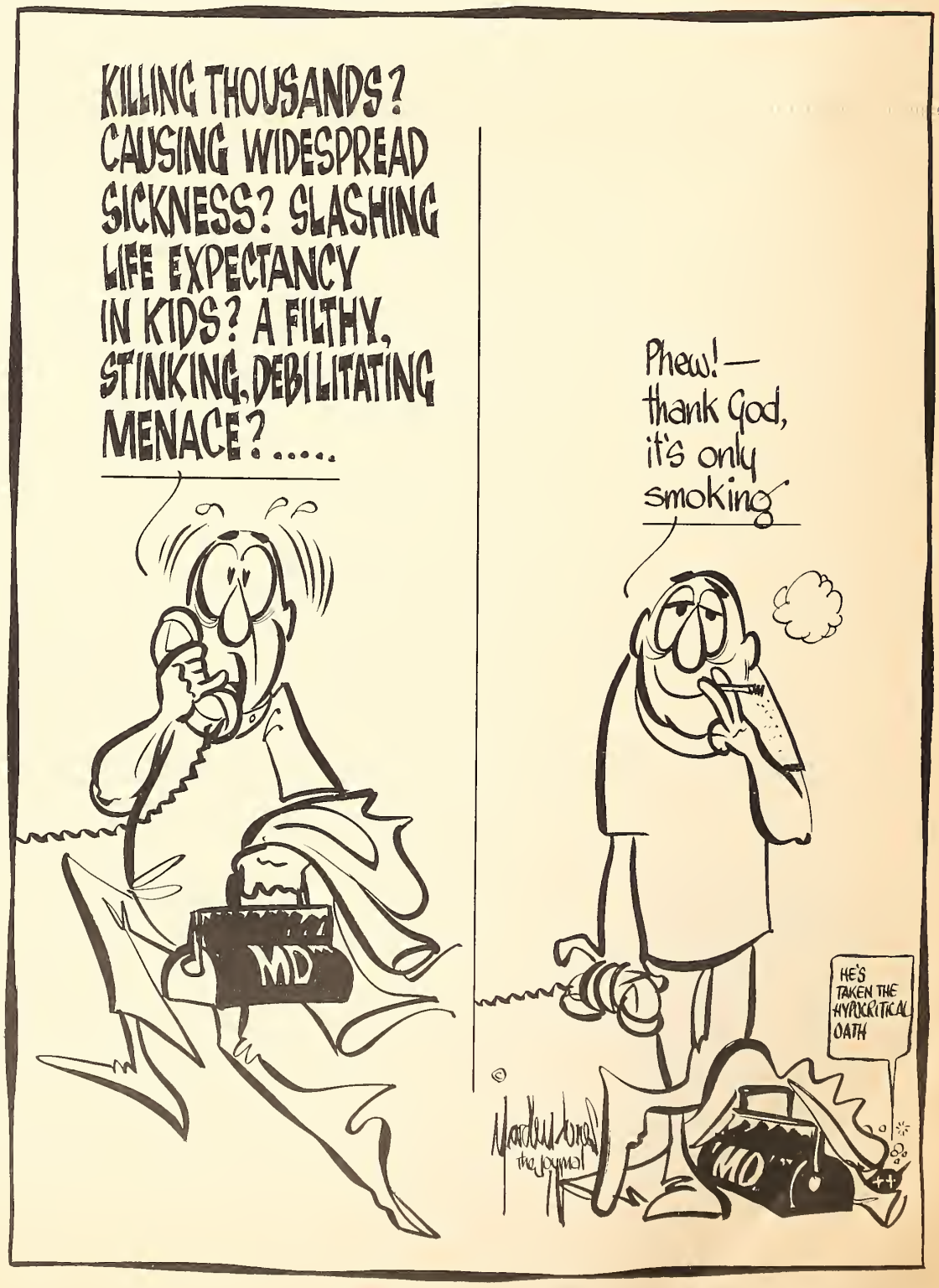


Malcolm Muggeridge: 'first-rate concepts.'

More on Malcolm

Donald Bastian's interview with Malcolm Muggeridge (**The Journal**, May) was quite interesting. Several classmates thought it had some first rate concepts — not what we get in the everyday media. Keep up the good work.

Stephen Knowles
Thunder Bay, Ont.



Editor... Letters to the Editor... Letters to the Editor...

'Poster undercuts church doctrine'

The Churches are probably Canada's most productive, continuing institution in matters of self-control and addiction-avoidance. While various denominations have different approaches to the problems of addiction, the result is usually the same. Active Church members and youth with strong religious convictions do not generally become addicted to drugs or alcohol. We do try to equip our youth to face reality rather than escaping from it via drugs and alcohol.

We believe there should be mutual trust and solidarity between the Addiction Research Foundation and the Churches.

'It's less than fair for ARF to undercut a traditional doctrine in the struggle for addiction-free living . . .'

Unfortunately, the poster which appears in **The Journal**, (July), created by James Cho of Caramat, Ont, is quite offensive to Christians of most, if not all, denominations. It clearly implies heaven is not a desirable place or condition. Somehow, the artist received an unfortunate impression of what the Gospel of the Church promises.

While the after-life is not the sole concern of most Churches who stress the importance of spiritual resources for life in this world, nevertheless eternal life and heaven are still important concepts and parts of the message and theology of Christianity.

The printing and distribution of 12,000 copies of this particular poster to schools will be indirectly counter-productive. It seems to be less than prudent or fair for the Addiction Foundation to be undercutting one of the traditional doctrines of an ally in the struggle for addiction-free living.

We hope you can find some way to substitute an alternate drawing. I'm sure our denomination's authorities will be interested in your reaction to our position.

J. M. Zimmerman
Executive secretary
Lutheran Church in America
Canada Section

Donald Murray, project leader of the 1979 Ontario Schools Poster festival, replies:

Concerning the poster designed by James Cho, your reactions, and those of the authorities of your denomination, are certainly matters of concern to us. There has historically been, to my knowledge, "mutual trust and solidarity" between the Foundation and the Churches.

The criteria employed by the judges in selecting the posters for reproduction encompassed many facets of the designs: impact, precociousness, practicability, and others, only one of which was the verbal message itself. We did not expect, and did not get, creative work of a professional calibre; most of the posters we received expressed simple dire warnings and exhibited an understanding of the complex phenomenon of alcohol abuse appropriate to school children. We are constrained to show these messages, as submitted, as the best examples, in our judges' opinion, of the children's work.

Specifically, the James Cho example, which will be clearly labelled as the work of a five-year-old, whose concept of heaven is as unformed as his concept of the consequences of alcohol abuse, will not, in our opinion, impede appreciably the acceptance of Christian Gospel.

With regard to your suggestion that we substitute another drawing: the winners have been selected, the prizes awarded, and the children have been promised that they will see their work in print. We are very reluctant to consider any alternatives to honoring that pledge.

Please accept that I understand and sympathize with your concerns. I hope you understand our reasons for continuing with the course we have set.

'We made kiss motto, thank you'

I note **The Journal** (April) states that the slogan "Kiss a Non-Smoker. Taste the Difference!" was developed in New Zealand.

In fact this slogan was developed in Australia by the Hunter Drug Advisory Service of the Health Commission of New South Wales. So you were only 1,100 miles out.

We devised the slogan after first hearing of the message developed by the United Kingdom Health Education Council, "Kissing a Smoker is Like Licking out an Ashtray." Although we thought their message had

potential, we wanted one with a positive impact. For this reason we turned the message around to create a favorable image for non smokers rather than just an unpleasant association for smokers.

Our slogan was developed in late 1977 and first used at the Annual Newcastle Show in February, 1978, at our display "Smoking or Health".

Raoul Walsh
Health Commission
of New South Wales
Hunter Region
Australia

Women/alcohol errors

I was delighted to see your coverage on women and alcoholism in **The Journal** (July), particularly my study on maternal drinking during pregnancy and its effects on daughters' age of menstruation.

However, because I use **The Journal** as a resource and I know many other people in the field who do, I felt I should point out a few errors in your article.

Delayed onset of menstruation was found in 80% (not 78%) of the daughters of heavy drinking mothers, compared to 54% (not 45%) of abstainers.

My name is Lucy Robe, not Rober. My study included 202 women (not 103) of which 79 were AA members (not 42).

Delayed onset of menstruation *was* found in later-than-first-born daughters of heavy drinkers: 79% of these "younger sisters" compared to 71% of abstainers' later-than-first-born daughters. We did report that this revealed no statistical significance.

It would appear your reporter used an abstract representing a preliminary study with a sample of 103 mothers, which was expanded to 202 for presentation at the Washington NCA Conference.

Thank you again for your coverage.

Lucy Barry Robe
Long Island
Council on Alcoholism

Gilbert stands by second-hand smoke claim

Columnist Richard Gilbert replies to critics of his February column on second-hand smoke.

I stand by every word of my February column: second-hand smoke *is* unpleasant and unpopular but not necessarily unhealthy. Mr Mahood and Dr Stewart (of the Non-Smokers' Rights Association) seem fond of quoting former United States Surgeons-General in support of their cause. The present Surgeon-General's 1979 report, *Smoking and Health*, released after I had written my column, seems entirely consistent with what I wrote, as the following quotations show:

". . . the literature [on second-hand tobacco smoke] is of recent vintage and only a limited amount of systematic information regarding the health effects of involuntary smoking on the nonsmoker is available."

"In summary, a substantial proportion of the normal population experiences irritation and annoyance on being exposed to cigarette smoke. The eyes and nose are the most sensitive to irritation, and the level of irritation increases with increasing levels of smoke contamination. Healthy nonsmokers exposed to cigarette smoke have little or no physiologic response to the smoke, and what response does occur may be due to psychological factors."

"Levels of COHb [i.e., blood-levels of carbon monoxide] produced by involuntary smoking situations are functionally insignificant in healthy individuals."

What I said to Toronto's Board of Health

The Non-Smokers' Rights Association seems to have as much difficulty as I do in remembering exactly what I said at the Board of Health on January 26, 1979: they have published at least three different versions of a particular part of my impromptu speech. What I was trying to say was that second-hand smoke is not *primarily* a health issue, that it can be and is regulated for other reasons, including unpleasantness and unpopularity, and that the Board of Health should devote its limited resources to problems such as lead pollution and food contamination, which no one else will deal with because they are seen primarily as health problems.

Advertising

Mr Mahood and Dr Stewart also took me to task for opposing an attempt by the Board of Health to ban advertising in and on Toronto Transit Commission (TTC) vehicles. I wasn't so much opposing the ban (although I must confess an aversion to censorship under any circumstances) as proposing something better. In spite of what Mahood and Stewart say, there is no clear evidence that advertising causes people to smoke. There is evidence, paradoxically, that antismoking ads might have some effect. My proposal was to have the TTC surcharge tobacco advertising, using the proceeds for anti-smoking ads.

My position seems consistent with the US Surgeon-General's 1979 report, which contains the following statements:

"The influence of the mass media on smoking behavior remains relatively unclear."

". . . the television medium appears to influence the formation of ideas and attitudes, yet does not 'trigger' adolescents to buy a product . . . cigarette ads are perceived by teenagers as hypocritical and are listed as 'least-liked' while antismoking ads are perceived as 'straightforward' and are liked."

Who speaks for ARF on tobacco

Mr Mahood and Dr Stewart suggest that *because I am a smoker* people should be concerned that I sometimes speak for the Addiction Research Foundation (ARF). Apart from the inaccuracy of the statement (I am not a smoker, at least not by the usual definition of the term, and I have never spoken for ARF) there is its astonishing implication that researchers on drug problems should be abstemious. Who would we ever find to work on alcohol and caffeine, used respectively by 80% and 90% of the adult population? How far should this principle be extended? Should sex researchers remain celibate, obesity workers eat no candy, and gynecologists be all male? Surely competence and experience are the important qualifications, not personal habit or biological predicament.

Why is it important to maintain a sense of proportion?

The Non-Smokers' Rights Association has urged us to believe that smoking and breathing second-hand smoke should be regarded as the same kind of hazard. They are not. To suggest that they are is to undermine the carefully constructed and overwhelming body of evidence that smoking is hazardous. Saying that milk and cyanide are both a hazard to health would make you wonder whether cyanide is so bad after all.

INTERNATIONAL

Europe tackles rampant drug use

Public health planners of the European Community are about to take action to reduce the volume and cost of the continent's consumption of pharmaceuticals. Critics argue that, given consumer society's vulnerability to drug dependence, the action has already been irresponsibly delayed, Thomas Land reports.

BRUSSELS — The European Commission is seeking to reduce the alarming drug dependence of modern consumer society. It is likely to start by curbing the intense advertising pressure directed at family doctors by the pharmaceutical industry.

The commission is the secretariat of the European Community with the political task of formulating common policy proposals to the council of ministers representing the member countries. The health ministers of the Community as well as the European Parliament have expressed growing concern both at the rapid rise in the volume and cost of the continent's drug consumption and at the increasing proportion of habit-forming stimulants and sedatives taken.

Sources close to the commission say that only the finishing touches are now needed to collective measures aimed at controlling this runaway consumption. Its proposals are for a compulsory reduction of advertising budgets promoting the drugs. It also wants advertising to be more informative to the consumer, prescribing improved information in place of gimmicks directed merely at stimulating sales.

Critics of the commission argue that, given consumer society's vulnerability to drug dependence, the promised action has been already irresponsibly delayed. Their point is illustrated by the widespread addiction to anorexiants — the appetite depressant medicines, nearly all of which contain amphetamines — whose use in Europe is described by specialists as growing in "epidemic" proportions.

Canada, Sweden, and Japan have already introduced measures to restrict the sale of the drugs; and the United States is expected to do so shortly. The department of health in France, a dominant member of the European Community, has even put anorexiants on the narcotics list. But they are still easily available in most of Europe.

Consider the danger signals of escalating dependence in France. A survey conducted by the National Institute of Health and Medical Research in 1972 concluded that 18% of secondary school children had experimented with the drugs. Another survey a year later showed that 30% of drug addicts in hospitals were on amphetamines (compared with 47% on heroin). By 1977, amphetamines were the most frequently taken drugs in pharmacy burglaries.

More than nine million units of anorexiants were legally sold during the same year in France alone to consumers who claimed to use the drugs to help them slim.

And the appetite depressants comprise a relatively small part of the problem. A specialist report on Europe's mounting drug consumption, compiled for the public health planners of the Community, recently forecast accelerating medical budgets largely to be consumed by the cost of pharmaceuticals.

Between 1966 and 1975, total drug consumption increased by 156% in France, 80% in West Germany, and 67% in Britain. Paradoxically, the total cost to the consumers includes the deteriorating general health standards due to over-medication.

The report, by B. Abel-Smith of the London School of Economics and P. Grandjean of Cours des Comptes in Paris, may well influence the European Commission's proposals for action. The authors observe that doctors paid directly by their patients are likely to prescribe them more medicines than their colleagues paid by national medical insurance schemes. The study also blames Europe's rapidly increased drug bill on intensified advertising pressure financed by the pharmaceutical industry and directed at doctors.

Other factors contributing to the rising cost of drugs include the longevity of the population as well as the need to replace old medicines with new, more effective, as well as more expensive varieties.

Community efforts to align national legislation on drugs have been hitherto restricted to quality control guarantees required before marketing. Direct action may now be taken at Community level at fixing prices and regulating medical practices and consumer behavior.

Action by public authorities has been timid in Europe, the specialist report says, although some sanctions have been taken against doctors who systematically prescribe expensive and non indispensible medicines. Some countries have also tried to curb over-medication by reducing the length of available treatment or the possibility of renewing prescriptions.

But such restrictive measures are frequently seen by doctors, pharmacists, and the public as an attack on individual liberty.

Sources close to the European Commission predict that its first step will be the introduction of standardized and coordinated controls on advertising. They may reduce the amount spent on drug promotion by the manufacturers and compel them to give more information about their products.

The commission is likely to argue that such an experimental approach could increase competition on the marketplace, ultimately serving the interest of the consumers.

Scots start 5-yr study

EDINBURGH — A grant of £80,000 from the Scotch Whisky Association will enable Edinburgh University to carry out a five-year program of research into the problems associated with alcohol and alcohol abuse.

It is planned that the money should be used to set up an alcohol research group in the university's department of psychiatry.

The first research worker appointed by the project is Dr Martin Plant, a sociologist. Dr Plant was formerly a Medical Research Council scientist and has carried out a number of studies into the prevention of alcohol abuse and patterns of drinking behavior among different Scottish social and occupational groups.

Drink bills high in UK

GENEVA — Britain spends more of its national food budget on drink than any other nation, according to an authoritative survey just published here by the United Nations' International Labour Organization.

About 18% of food budgets in Britain is spent on alcoholic beverages, closely followed by Australia and Greenland with about 16% each. In the Republic of Ireland, it is about 12% to 15%; Canada, 14%; Czechoslovakia, Papua New Guinea and New Zealand, 11.5% to 12%; Malawi and Sierra Leone (urban households) about 10%; Denmark, Sweden, and France, 8.8% to 9.5%. The American family spends about 6% of its food and drink budget on alcoholic beverages.

'If heroin trade is not stopped, parliament itself must act...'

Heroin underworld scene shocking New Zealand

By Tony Garnier

WELLINGTON, NZ — The "it-can't-happen-here" attitude of some New Zealanders to heroin trafficking and the Mafia-like underworld it is creating, has been ripped away by disclosures at parliament that prominent New Zealanders are deeply involved.

The disclosures coincided with the finding of the buried bodies of a New Zealand couple, murdered allegedly by an Australian-based but New Zealand-run narcotics ring. The group is said to be responsible for five other unsolved murders including those of at least three more New Zealanders.

Labour's Junior Opposition Whip Richard Prebble made the disclosure in parliament. He said he decided to "put his head on the block" and read in parliament a banned television transcript about drug running because the drug trade was feeding off the fact that New Zealand is a closed society and libel laws are so tight.

New Zealanders, he said, were being murdered over drugs, and while police were doing their best, the problem was so big that only parliament had the power and ability to take the extraordinary measures to combat drug trafficking.

The transcript named some prominent New Zealanders and the television channel that prepared it had been advised that action for defamation was possible if the film was screened.

In itself, the television script contained, as the police later admitted, little that they did not already know. It claimed to trace a voyage of a luxury yacht round the South Pacific with calls at ports where heroin could have been loaded.

But, Mr Prebble's move has forced the government to try to find some answers to many questions troubling New Zealanders about the narcotics trade. The number of people appearing in court on narcotics charges is doubling each year, yet the government and the police appear to have had little success in tracing the masterminds who are said to be reaping the profits in a $100 million business.

Some Members of Parliament responded to Mr Prebble's disclosure by calling for the restoration of the death penalty for drug dealers. Dealers were the slave traders of modern times, said one MP.

But the courts are already imposing severe penalties, even on small dealers. The problem is to catch the bosses.

In his dramatic bid to trigger action, Prebble told parliament: "We have a situation where our police force appears to be fighting a losing battle and our media are convinced that to investigate this menace would be to invite a crippling libel suit — and they're probably correct. If this heroin trade is not stopped, then parliament itself, I believe, must act."

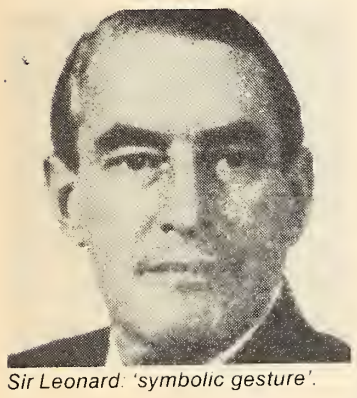
He called for the establishment of a special investigative committee of MPs to probe the issue. He argues that though none of the "Mr Bigs" in the New Zealand drug scene have been caught or named, the public is entitled to know who they are.

Prime Minister Muldoon has rejected the Prebble plea. Hearings in a parliamentary select committee, he said, would be turned by Mr Prebble and his colleagues into a public circus. However, the Muldoon response has done little to allay public concern about the situation.

Nor is the publicity surrounding the Prebble disclosures likely to frighten off the traffickers. Last year in Auckland alone $40 million is reputed to have changed hands for heroin.

New Zealand government agencies are employing the most sophisticated methods to track down traffickers and dealers: the question the government is now under pressure to answer is why its forces and equipment have yet to succeed in crippling their trade.

Go drinkless, Nz'ers urged



Sir Leonard: 'symbolic gesture'.

AUCKLAND, NZ — With carless days in prospect for New Zealanders facing a fuel shortage, drinkless days have been proposed as a token of independence from alcohol.

"It would prove that you don't need the stuff, and it would be a sort of symbolic gesture," said the chairman of the Alcoholic Liquor Advisory Council, Sir Leonard Thornton, when he suggested the idea.

"I think every family should set aside one day a week when they will not have a drink, or perhaps one day a month, or a year even — just to prove they're not hooked on it."

He suggested the government might give a lead, and Members of Parliament should state that they would not drink on one day a week while parliament is in session.

Burma gets own meds

TORONTO — Smugglers pay illicit heroin producers in Burma virtually the same price whether the heroin is destined for international or local markets.

As a result, the local market for opium harvested and processed in the mountainous Golden Triangle, where the borders of Burma, Thailand, and Laos meet, has increased in recent years, according to a report in the *New York Times*.

In a dramatic increase from the mid-1970s, Burma now has about 30,000 registered heroin addicts and an estimated 100,000 users, the report said.

The big difference between markets is the street price and the quality of the heroin. A small packet costs about $3 in Burma and $20 in New York. Furthermore, Americans knowledgeable about heroin production and sales said heroin reaching New York is 3% to 5% pure, while in Burma it's 90% to 95% pure.

Although the governments of Burma and Thailand have recently pledged cooperation in fighting opium growth and processing, Burmese officials are said to be more concerned with suspected political insurgencies than with drug enforcement.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Jenny Cafiso, coordinator of the group at (416) 595-6150.

Dial A-L-C-O-H-O-L: In The Beginning

Subject Heading: Attitudes and values, alcohol and the family.
Details: 30 minutes, 16 mm, color, sound.
Synopsis: Liza and Peter are to be married. Pete's family are caterers. A wine merchant is determined to provide champagne for the reception. Liza's family are devout Baptists and refuse to have alcohol served. The wedding is called off. Interspersed with the story of Pete and Liza is the story of the Dial Alcohol centre. Here, young people are helping other cope with alcohol problems. Liza goes to the centre with her friends and Pete finds her there. They decide to hold their wedding at the centre and let the parents hold separate receptions.
General Evaluation: Very poor to poor (1.6). Poorly produced technically, this boring and unrealistic film was deemed a poor teaching aid.
Recommended Use: Although the film seemed to be intended for audiences of 15 years of age and older, because of its shortcomings, it's not likely to benefit anyone.

The Tobacco Problem: What Do You Think?

Subject Heading: Smoking.
Details: 17 minutes, 16mm, color, sound.
Synopsis: Smoking is a harmful activity in which many people indulge. Research has shown many of these harmful effects. Cilia in the lungs can't perform their cleansing activity; the heart rate is speeded up, coronary artery disease develops. Lung sections are shown with gaping holes, the result of deterioration due to smoking. Young people are shown in a group talking about the evidence they have just witnessed. They express their opinions as to why some of their peers smoke.
General Evaluation: Very good (4.9). An informative, interesting, realistic, and contemporary film with a clear message, this technically well produced film was rated an effective teaching aid. The film could produce attitudes opposed to smoking, and could help in decision-making regarding smoking. Public broadcast was recommended.
Recommended Use: Likely to benefit general audiences of eight years of age and older. The film would also be useful in special groups such as Smoke Enders.

Jackson Junior High: Route 1

Subject Heading: Alcohol pharmacology.
Details: 15 minutes, 16 mm, color, sound.
Synopsis: In a junior high school class, a teacher is giving a lecture on alcohol. Patches, a St Bernard is outside the class window and is distracting the students. Patches had drunk too much champagne and is suffering a hangover. Using an animated sequence in which alcohol travels through the blood stream, the teacher explains how alcohol affects the body. The teacher uses Patches' experience to illustrate the process of metabolism and explains that time is the only cure for a hangover.
General Evaluation: Very good (5.1). This contemporary, informative, and interesting film with a clear message was technically well produced. Its length was considered suitable for most educational purposes. The group particularly liked the animated sequence and considered the film to be an effective teaching aid. The A/V Group felt the film could produce attitudes opposed to drug abuse and help in decision making regarding drug use. Public broadcast was recommended.
Recommended Use: Likely to benefit audiences of eight to 14 years of age.

Gay, Proud And Sober

Subject Heading: Alcohol and alcoholism overview.
Details: 22 minutes, 16mm, color, sound.
Synopsis: For many years, gay people have been using gay bars to socialize. Generally, a high level of alcohol consumption is part of this atmosphere. Some people have used alcohol to build up their courage to face their homosexuality. For these reasons, gay people have an unusually high rate of alcoholism, yet societal misunderstandings and discrimination have made it difficult for gay alcoholics to obtain treatment that meets their unique needs. The film proceeds from the premise that, if properly addressed by a sensitively structured counselling program, homosexual positive affirmation of their sexual orientation can be used as a valuable tool to help in controlling their drinking.
General Evaluation: Good (4.6). A contemporary, informative and realistic film with a clear message, this well produced film was rated an effective teaching aid. Public broadcast was recommended.
Recommended Use: Likely to benefit audiences of twelve years of age and over, drug users, health professionals, and the gay community.

NEW MATERIALS FROM ARF

GUIDES

P-151 **DIAGNOSIS AND TREATMENT OF ALCOHOLISM FOR PRIMARY CARE PHYSICIANS** **$1.95**

A 36 page handbook on alcoholism developed for the primary care physician in conjunction with the Ontario Medical Association. A "how-to" guide dealing with identification, diagnosis, short and long-term management in both the medical and psycho-social senses. Invaluable to the medical practitioner.

P-160 **TEN LESSON PLANS FOR GRADES 7 AND 8** **$7.95**
P-161 **TEN LESSON PLANS FOR GRADES 9 AND 10** **$7.95**

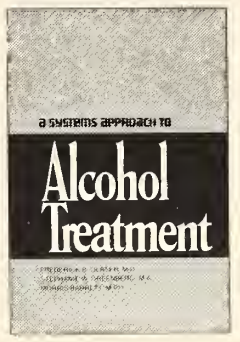
The program consists of two sets of 10 lesson plans. Each lesson deals with a separate topic and can be used independently. Developed in conjunction with the Toronto Board of Education. The lesson plans provide the teacher with as much information concerning alcohol and the process of teaching about alcohol as is possible. Includes suggestions for A/V and other materials to enhance the program. The Ontario Ministry of Education has reviewed the lesson plans and found them to fit Ministry guidelines.

BOOK

A SYSTEMS APPROACH TO ALCOHOL TREATMENT

Authors: Frederick B. Glaser, M.D.
Stephanie W. Greenberg, M.A.
Morris Barrett, M.P.H.
$14.95

A major work which provides the results and conclusions on the system of alcoholism treatment programs within a large geographic area. The book provides a factual base from which to proceed toward developing a systematic alcoholism service delivery program. Will be of interest to administrators, organizational and policy personnel, and the general health care professional.



VIDEO CASSETTE

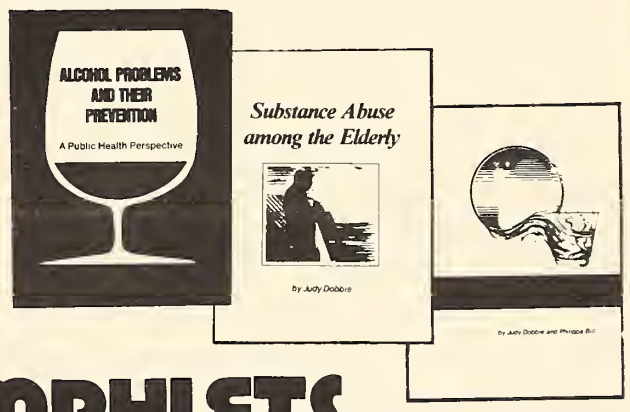
V-028 **MARIJUANA - THE FACTS** **$95.00**
25 Minutes, Color

Target Audience: Teachers, social workers, health professionals, and general audiences of mid-teens and older. Especially useful in learning or teaching situations.

Content: What is marijuana and what does it look like?
Is it addictive?
Effects compared to alcohol?
Does use lead to harder drugs?
Would use be beneficial for particular medical problems?

PAMPHLETS

P-109 **THE FETAL ALCOHOL SYNDROME** **40¢ each**
P-110 **SUBSTANCE ABUSE AMONG THE ELDERLY** **40¢ each**
P-111 **ALCOHOL PROBLEMS AND THEIR PREVENTION —A PUBLIC HEALTH PERSPECTIVE** **40¢ each**



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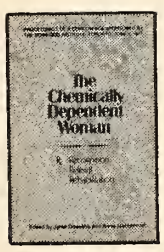

P-265 **$4.95**

THE CHEMICALLY DEPENDENT WOMAN

The published presentations resulting from a conference on women's issues, hosted by the Donwood Institute, Toronto. A distinguished group of presentors, including Dr. Gordon Bell and Ms. Jan Du Plain, address issues of usage, patient and physician perspectives, treatment trends, and new directions for women.

P-266 **$4.95**

SOLVENTS, ADHESIVES, AND AEROSOLS

The published presentations resulting from a seminar hosted by the Ministry of Industry and Tourism and the ARF on the use and misuse of these substances. The volume contains papers on historical review, legal considerations, community approaches to treatment, industrial perspectives, and a keynote address on international trends by Dr. Sidney Cohen of U.C.L.A.'s Neuropsychiatric Institute.

P-267 **$14.95**

INTERNATIONAL COLLABORATION: PROBLEMS AND OPPORTUNITIES

Proceedings of a two-day international seminar marking the designation of the Addiction Research Foundation as a collaborating centre of the World Health Organization.

Areas of discussion include: the epidemiology of alcohol and other drug-related problems, control strategies, and international collaboration in drug abuse programs.

Order by catalogue number from: **MARKETING SERVICES, ADDICTION RESEARCH FOUNDATION**
33 RUSSELL STREET, TORONTO, CANADA M5S 2S1
TELEPHONE: (416) 595-6056

New Books

by RON HALL

Kids And Drinking

. . . . *by Anne Snyder*

Designed for public school children, this illustrated book offers information about drinking and alcoholism. From first-hand experience with some of these children, the author tells the stories of three who are now recovering from alcoholism. The development of drinking into a disease which affects home life, social relationships, and school work is presented. A 20-question self-test is included to help young people recognize their own alcoholic symptoms.

(CompCare Publications, PO Box 27777, Minneapolis, MN, 55427. 1977. 56p $2.50.)

A Dangerous Pleasure

. . . . *by Geraldine Youcha*

This book is an attempt to provide information concerning women and alcohol. It brings together research, opinion, and human experience to present a picture of what is known about how drinking affects women. The author, a reporter, has tried to present the controversies as well as the few certainties. Topics presented include: drinking habits; effects on the body and brain; women alcoholics; alcohol and the family; alcohol and pregnancy; and treatment of alcoholism. The appendix provides a guide to sensible drinking, an alcoholism checklist, and alcoholism treatment and information resources.

(Prentice-Hall of Canada, Ltd, 1870 Birchmount Road, Scarborough, Ontario, M1P 2J7. 1978, 251 p. $13.95.)

You And Your Heart: How to Take Care of Your Heart for a Long and Healthy Life

. . . *by Paul Kezdi*

Divided into three major sections, this book provides information on what one should know about the heart, the factors that affect it, and how to keep it healthy. Included are chapters which deal with the effects of drinking and smoking, as well as how to choose appropriate food and drink, and how to stop smoking. The chapter devoted to drinking covers many beverages including coffee, tea, water, alcohol, and other liquids.

(McClelland and Stewart Ltd, 25 Hollinger Road, Toronto, Ontario, M4B 3G2. 1978. 267p. $6.50)

Diagnosis and Treatment of Alcoholism for Primary Care Physicians

This handbook on alcoholism was developed for the primary care physician by the Addiction Research Foundation in conjunction with the Ontario Medical Association. It is a "how-to" guide dealing with identification, diagnosis, and short and long term management in both the medical and psychosocial senses.

(Addiction Research Foundation, Marketing Services, 33 Russell Street, Toronto, Ontario, M5S 2S1. 1978. 40p. $1.95.)

Other Books

Self-Administration Of Abused Substances: Methods For Study — Krasnegor, Norman, A. (ed). National Institute on Drug Abuse, Rockville, 1978. Papers with references presented at a technical review held Feb, 1978 in Reston, Virginia. Drugs, ethanol, food, tobacco. 245p.

Liquor And Poverty: Skid Row As A Human Condition — Blumberg, L.U., Shipley, T. F., and Barsky, S. F. Rutger, New Brunswick, NJ, 1978. Bibliography, index. Monographs of the Rutgers Center of Alcohol Studies No 13. Appendices include notes on some Philadelphia Welfare Agencies. 289p. $14.

Halfway Houses For Alcoholics — Ogborne, A.C., Annis, H.M., and Sanchez-Craig, M. Addiction Research Foundation, Toronto, 1978. Report of the Task Force on Halfway Houses, prepared for the President, ARF. Appendices include submissions, selected characteristics of residents, proposals relevant to a human caretaking approach to skid row alcoholics. 82p.

International Statistics On Alcohol Beverages, Production, Trade and Consumption 1950-1972. — The Finnish Foundation for Alcohol Studies, Helsinki, 1977. The Finnish Foundation for Alcohol Studies, Vol 27. Part of a collaborative project on alcohol consumption and its relation to public health undertaken by the Finnish Foundation for Alcohol Studies together with the Addiction Research Foundation of Ontario, and the WHO Regional Office for Europe. 231p.

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Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

20th Annual Institute On Addiction Studies — Aug 19-24, Hamilton, Ontario. Information: Mr D. Smyth, Institute on Addiction Studies, 15 Gervais Dr, Suite 603, Don Mills, Ont, M3C 1Y8.

Summer School On Alcohol And Drugs — Aug 20-24, Calgary, Alberta. Information: Ms A. Steiestol, Conference Secretary, Summer School on Alcohol and Drugs, 812-16 Ave, SW, 2nd Floor, Calgary, Alta, T2R 0T2.

4th Annual Symposium — Pharmacotherapy With Emotionally Disturbed Children — Sept 20-21, Toronto, Ontario. Information: Ms A. E. Parsons, Community Relations Officer, Thistletown Regional Centre for Children and Adolescents, 51 Panorama Court, Rexdale, Ont, M9V 4L8.

Input '79 — 3rd Biennial Canadian Conference On Occupational Alcoholism And Drug Abuse — Sept 23-26, Ottawa, Ontario. Information: Input '79 headquarters, Conference and Seminar Services, Humber College of Applied Arts and Technology, Box 1900, Rexdale, Ont, M9W 5L7.

Clinical Orientation To Alcohol And Drug Dependence Seminar — Sept 24-28, Nov 19-23, Toronto, Ontario. Information: The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ont M4G 3Z1.

29th Annual Meeting Of The Canadian Psychiatric Association — Sept 26-28, Vancouver, BC. Information: Canadian Psychiatric Association, Suite 103, 225 Lisgar, Ottawa, Ont, K2P 0C6.

Canada Safety Council's 11th Annual Safety Conference — Sept 30-Oct 3, Quebec City. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario, K1G 3V4.

17th Annual Scientific Assembly Of The College Of Family Physicians Of Canada — Ontario Chapter — Oct 14-17, Toronto, Ontario. Information: The Executive Secretary, Ontario Chapter, College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ont, M2K 2R9.

Detox Training Program — Oct 15-19, Nov 12-19, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

OAPSW 15th Anniversary Annual Conference — Nov 15-17, Geneva Park, Orillia, Ontario. Information: Ontario Association of Professional Social Workers, 696 Yonge St, Suite 501, Toronto, Ont, M4Y 2A7.

United States

14th Annual Teenage Institute On Alcohol And Other Drugs — Aug 5-9, Gambier, Ohio. Information: Teenage Institute Coordinator, Ohio Department of Health, Division of Alcoholism, PO Box 118, Columbus, Oh, 43216.

11th Annual Summer School On Alcohol And Other Drugs — Aug 6-17, Berkeley, California. Information: Dr H. J. Kregel, Director, Berkeley Center for Alcohol Studies, Pacific School of Religion, 1798 Scenic Ave, Berkeley, Ca, 94709.

4th Annual Conference On Employee Assistance Programs In Higher Education — Aug 8-10, Newport, Rhode Island. Information: Employee Assistance Program, University of Missouri-Columbia, 215 Columbia Professional Building, 909 University Ave, Columbia, Missouri, 65201.

8th Annual San Diego Summer School And Drug Studies Program — Aug 19-24, San Diego, LaJolla, California. Information: Ms K. Lockwood, UCSD Extension, X-001, University of California, San Diego, LaJolla, Ca, 92093.

6th National Drug Abuse Conference — Aug 26-30, New Orleans, Louisiana. Information: NDAC '79, 115 S Chestnut St, Lafayette, Louisiana, 70501.

30th Annual Meeting Of The Alcohol And Drug Problems Association Of North America (ADPA) — Aug 26-30, Washington, DC. Information: Driscoll and Associates, 1925 North Lynn St, Suite 1001, Arlington, Virginia.

4th International Conference Of Therapeutic Communities — Sept 16-21, New York City. Information: Charles Devlin, Coordinator, Daytop Village, Inc, 54 West 40th St, New York, NY, 10018.

Association Of Labor-Management Administrators And Consultants On Alcoholism (ALMACA) — Oct 2-6, Detroit, Michigan. Information: ALMACA, 1800 North Kent St, Suite 907, Arlington, Virginia, 22209.

23rd Annual Conference Of The American Association For Automotive Medicine — Oct 3-6, Louisville, Kentucky. Information: AAAM, PO Box 222, Morton Grove, Illinois, 60053.

Evaluation Of The Alcoholic: Implications For Research, Theory And Treatment — Oct 12-13, Hartford, Connecticut. Information: Mrs M. Meadows, Alcohol Research Center, Dept of Psychiatry, University of Connecticut Health Center, Farmington, Ct, 06032.

Annual Meeting Of The Society Of Forensic Toxicologists — Oct 31-Nov 2, Williamsburg, Virginia. Information: Robert V. Blanke, Medical College of Virginia, MCV Station, Box 696, Richmond, Va, 23298.

National Conference On The Problems And Preventions Of PCP Abuse — Nov 3-4, San Francisco, California. Information: Stephanie Ross, Haight Ashbury Training and Education Project, 409 Clayton St, San Francisco, Ca, 94117.

Training Institute On Addictions — Dec 9-14, Miami Beach, Florida. Information: Training Institute on Addictions, c/o Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, Co, 80901.

Abroad

3rd World Congress Of The International Commission For The Prevention Of Alcoholism And Drug Dependency — Aug 26-31, Acapulco, Mexico. Information: ICAP executive director, 6830 Laurel St, NW, Washington, DC, 20012.

10th International Conference On Health Education — Sept 2-7, London, England. Information: The Conference Centre, 43 Charles St, Mayfair, London, W1X 7PB, England.

International Conference On Alcoholism And Drug Dependency — Sept 3-7, Tegucigalpa, Honduras. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Symposium On Addictions: Biochemical Mechanisms Of Dependence And Brain Damage — Sept 13-14, Oxford, England. Information: The Helping Hand Organization, c/o The Alcohol Education Center, 99, Denmark Hill, London, SE5 8AZ, England.

9th International Institute On The Prevention And Treatment Of Drug Dependence — October, Madrid, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1st Pan-Pacific Conference On Drugs And Alcohol — Feb 26-Mar 7, 1980, Canberra, Australia. Information: Pierre Stolz, AFADD, PO Box 477, Canberra City, ACT 2601, Australia.

26th International Institute On The Prevention And Treatment Of Alcoholism And International Institute On The Prevention And Treatment Of Drug Dependence — June, 1980, Cardiff, Wales. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

MDs in best position to help smokers quit

BY DAVID WOODS

TORONTO — Pointedly turning upside down the ashtrays provided for them by the hotel, panelists at a recent one-day "invitational symposium on smoking cessation" fielded a variety of questions from some of the 220 registrants. If there was any consensus it was that cigarette smoking is public health enemy number one; that nicotine is the villain of the piece; and that family physicians are ideally placed to play St George and slay the tobacco dragon.

Earlier at the symposium, sponsored by the College of Family Physicians of Canada, but with Dow Chemicals, makers of a heavily-advertised nicotine chewing gum, unobtrusively picking up the tab, British psychiatrist Michael A.H. Russell had described cigarette smoking as the most addictive form of object-specific gratification know to man.

Dr Russell, internationally known for his work on smoking cessation, said the drug in cigarettes is nicotine and the cigarette is a mighty effective device for getting it into the brain. A syringe might be quicker if you stuck it into someone's head, he suggested, but nicotine injected into the arm takes 14 seconds to reach the brain; inhaled from a cigarette it takes only six seconds.

So each puff, said Dr Russell, is an intravenous-like shot of the stuff; a pack-a-day smoker gets 70,000 shots a year.

Noting that three of four smokers want to quit the habit, and that the more cigarettes a person smokes, the more difficult quitting is perceived to be, Dr Russell said he's disturbed by a British survey of public knowledge about risk factors in smoking; only half of those polled, he said, thought smoking "can help cause" heart disease, for example, and 66% of smokers and 80% of non smokers felt it could "help cause" lung cancer.

Dr Russell referred to another study involving more than 1,800 people: one group served as a control; one group received a questionnnaire about smoking habits; a third group was given advice about smoking from their general practitioners; and a fourth got the GPs' advice plus a pamphlet on smoking to take away with them.

After one year, 0.3% of the controls had quit; 1.6% of the questionnaire receivers; 3.3% of the GP-advised; and 5.1% of the advice and pamphlet group. That was with 28 GPs, he said; imagine what *all* general practitioners could achieve.

Family physicians, he said, can get at the entire population — smoking withdrawal clinics get only the motivated. Dr Russell cited a Philadelphia questionnaire mailed to 30,796 people. Of these, 11,477 were smokers; 4,775 wanted to quit; 150 attended a stop-smoking clinic . . . and 35 had abandoned the habit after one year.

Nor is nicotine chewing gum the miraculous cure most smokers are looking for, said Dr Russell, although it does enable them to break the habit in two stages: first off the smoke; then off the nicotine habit. Twenty per cent of its effect stems from the nicotine in it, said Dr Russell, but there's also a strong placebo effect.

RUSSELL: *'If we can't deal with smoking, how can we deal with schizophrenia...?'*

Q. What attracted you to this field?
A. It's the most important challenge to preventive medicine in the Western world. More people die of smoking than of any other cause. As a psychiatrist I'm interesed in behavior; if we can't get far with a simple thing like smoking . . . what are we going to be able to do about, say, schizophrenia?

Q. Shouldn't we be able, though, to go to hell in our own way?
A. Well, yes. But three-quarters of the people who smoke want to stop. I agree that it's unfair to push people into stopping if they don't want to; but clearly many smokers are unaware of the risks involved. They must be informed.

Q. But that takes money, and the tobacco companies spend millions promoting cigarettes.
A. There's a need to equalize those budgets with the ones for ads explaining the risks. But do you cut the former and add to the latter? The United States had the right idea in the 1960s, saying that for every five minutes of television ads promoting smoking, the companies had to devote funds to one minute's advertising by the anti-smoking forces. That worked. People were stopping.

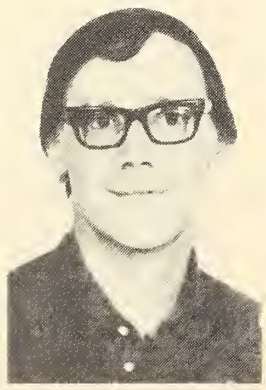
Q. Now the TV ads for cigarettes are banned . . .
A. I'm generally against banning, because most people want to ban what *they* don't like. It becomes repressive. But I think the effects of advertising are exaggerated. There's none in the USSR or China, yet people smoke a lot in both those countries. I am concerned, though, about the way cigarettes are being pushed in the Third World countries.

Q. What about the so-called "safe" cigarette?
A. None is safe. But a less harmful cigarette should be supported, and research intensified. It's going to be years before cigarette smoking is reduced significantly, and it's silly to wait for that when you can lower tar intake. One temporary solution might be cigarettes with lower tar and higher nicotine. That can be done. But if smoking does get a little "safer," there's going to be less motivation to give it up.

Q. What's your view of the cellulose-fibre, tobacco-substitute cigarettes being marketed in the United Kingdom?
A. They're not selling very well, because they're low in nicotine.

Q. Only 20% of Canadian physicians smoke. That's less than half the rate for the population at large. Is that why you see MDs as mentors?
A. It's more a matter of cost effectiveness: general practitioners can get to such a large audience.

Q. Certainly in Canada one has the impression that smokers are becoming increasingly defensive and apologetic . . .
A. Yes, you do get anti-*smokers* as opposed to anti-smoking disease people. Moralists. Some of them would be almost disappointed if a safe cigarette *were* found. There'd be nobody around to bash.



Michael Russell is senior lecturer, Institute of Psychiatry, and Hon. consultant psychiatrist, at the Maudsley Hospital, London, England.

THE BACK PAGE

Fighting words...

For anyone looking for ammunition in the war against smoking, the symposium was a well-stocked arsenal. Registrants learned that:
*** The Surgeons General's report weighs 900 grams.**
*** 350,000 deaths in North America each year are attributable to smoking.**
*** A 30-year-old male non smoker can look forward statistically to another 44 years of life; his pack-a-day counterpart has 38 years left.**
*** Offspring of smoking mothers weigh 200g less at birth and are susceptible to more abnormalities.**
*** Smoking-related health costs in Canada are $135 per capita a year.**
*** Smoking alters the metabolism of drugs.**
*** British Columbia has the highest proportion of ex-smokers in Canada.**
*** Health and Welfare Canada spent $685,000 this year on smoking-related education and research.**
*** Governments are addicted to smoking because of the enormous revenues they derive from it.**
*** Nicotine gets to the brain faster than heroin.**
*** A 1976 US survey showed that if all cigarette smokers could reduce their consumption to 10 a day, cancer of the lung would be reduced by 83%.**

The question, largely unresolved at the symposium, is how to load all this weaponry, aim it, and hit the target.

Heroin/cocaine crime up, pot down

By Jeff Carruthers

OTTAWA — The number of actual drug offences in Canada has declined for the second time in a row, according to preliminary crime statistics for 1978 being prepared by Statistics Canada.

Behind the drop is a 5% decline in the number of cannabis offences, the category that continues to dominate Canada's drug statistics.

However, heroin and cocaine offences, while small in number compared to cannabis, jumped dramatically in 1978 — by 19% for heroin to 1,221, and by 16% to 1,030 for cocaine.

Total number of actual drug offences dropped by 4.8% to 60,747 in 1978 compared to 63,843 the year before.

Offences involving the cannabis drugs, marijuana and hashish, reported to Statistics Canada by police dropped by 5% to 53,378 from 56,447 in 1977. However, even with the drop, cannabis offences continue to dominate the drug crime statistics, making up 87.8% of the offences catalogued in 1978, down only slightly from 88.4% the previous year.

As might be expected, cannabis possession offences in turn dominate the cannabis statistics — 44,604 of 53,378 compared to 7,634 for trafficking, 337 for importation, and 803 for cultivation.

In the case of heroin offences, the crimes are pretty evenly split into possession, with 586 of 1221, and trafficking at 598. The remaining 37 are for importation of heroin.

In the case of cocaine, trafficking offences dominate at 553 of 1,030; possession involved 383 cases, importation 104.

Offences involving controlled drugs, mainly the amphetamines, totalled 1,022. Those involving restricted drugs, mainly hallucinogens such as LSD, totalled 1,832, with 1,089 for possession and 743 for trafficking.

The Statistics Canada figures, which are expected to be published early in November, also highlight the number of cases reported to police but discovered to be unfounded on subsequent investigation. These would involve, for example, telephone call reports from suspicious neighbors or suspicion by police themselves.

Overall, there were 5,450 such unfounded cases: 4,254 involved cannabis, 122 involved heroin, 167 involved cocaine.

Even after initial investigations, a large percentage of the cases never resulted in actual charges. There were 6,806 such cases, of which 6,105 involved cannabis, 74 heroin, and 70 cocaine.

Statistics Canada also breaks down the cases on the basis of sex and age with a large percentage of the juvenile cases not resulting in charges.

For example, for all the drug offences, 43,777 adult males and 5,098 adult females were charged, 2,087 male juveniles and 378 female juveniles were charged, and 1,301 juveniles were not charged.

Again these overall statistics were heavily influenced by cannabis offences: 39,326 adult males were charged, 4,016 adult females were charged, 1,954 male juveniles and 354 female juveniles were charged, and 1,227 juveniles were not charged.

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The Journal

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BC's plan 'wide open'

By Tim Padmore

VANCOUVER — The "locked" doors of British Columbia's compulsory heroin treatment plan are standing wide open.

Addicts are walking out of a 150-bed residential treatment facility at will, therapists are often frustrated by interruptions in their treatment plans, and what was conceived as one of the world's most coercive drug treatment schemes is, in the words of the plan's director, "one of the most non-coercive programs anywhere."

The situation is the result of an unresolved constitutional challenge to the heroin legislation. Pending a resolution, the Alcohol and Drug Commission, which administers the plan, has suspended enforcement of the compulsory provisions.

It is not a crippling problem, says Jack Altman, the plan's director (The Journal, Aug). Perhaps two or three addicts walk out of the Brannan Lake facility in any two week period, while there are 40 to 50 people in treatment at any one time.

But it has spawned rumors and confusion.

A rumor that the facility is awash in illicit drugs is false, Mr Altman said. In the first three months of operation, periodic spot checks turned up two syringes, two methadone tablets, and one addict high on smuggled narcotics, he said.

A likely source of the rumor of heavy drug use is urine tests that are positive when the addict is first admitted and each time he is re-admitted after walking out, Mr Altman said.

A contrasting story was told by Chris, a female addict who walked out of Brannan Lake five weeks after volunteering for treatment there.

"Some of the addicts seemed to be making progress there but a lot of them were stoned half the time .... Believe me, there was a lot of dope available," she said at an interview arranged by a group opposed to the heroin plan.

Alcohol and Drug Commission chairman Bert Hoskin said there had been some laxity by one nurse in checking for illicit drugs, but the nurse has been put on other duties and the situation rectified.

Pills precipitating more crashes than alcohol

By Jane Dornberg

HAMBURG — Pills are surpassing alcohol as the major cause of traffic accidents, according to German doctors at a recent Hamburg conference on traffic medicine, sponsored by the German automobile club, ADAC.

Since road users under the influence of medication rarely display the overt symptoms of alcohol users, the problem is harder to detect. Thus, statistics which attribute one accident in four to alcohol, give drugs a mere fraction of a percent as the culprits.

However, Wolfgang Arnold, head of forensic medicine at Hamburg University, says surveys conducted jointly with the surgical wards of Hamburg University Hospital, indicate that the number of traffic accidents due solely to the influence of pills appears to exceed those caused by alcohol.

In 68% of the cases probed, the urine of motorists or pedestrians who had been responsible for road accidents was found to contain traces of medicines.

One of the surveys, Professor Arnold states, indicated that 50% of those asked admitted to taking pills without having first consulted a doctor. Half again drove despite the fact that nine out of 10 were completely aware of the possible effects of drug intake, in general, and on road safety, in particular. Fourteen to 20% ignored the advice of their doctors or went against their own feelings that they are not at their best when driving under the influence of drugs.

Drugs taken for serious diseases such as endogenous psychoses or epilepsy, the dosages of which are carefully explained and supervised, are not a problem, according to Hanns Hippius, a Munich psychiatrist. The problem is the indiscriminate use of tranquillizers, sleeping pills, pep pills, and painkillers without medical advice or necessity, by perfectly healthy people.

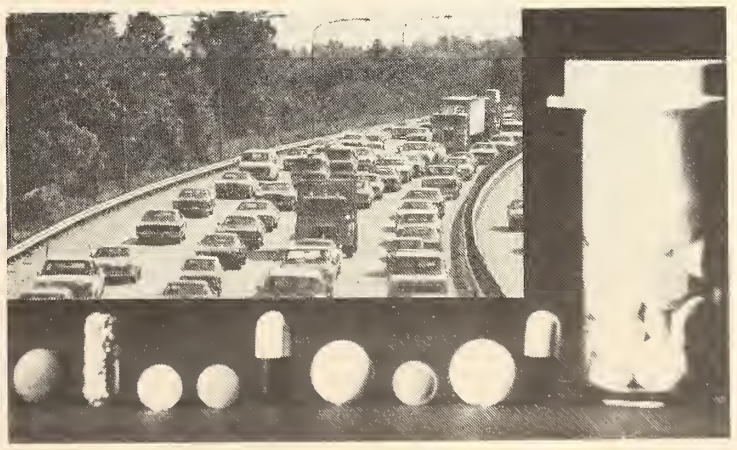
"Every intake of psychically effective substances must be regarded as a potential traffic risk factor in every individual without exception," Professor Hippius says.

The situation is particularly acute regarding combinations of several drugs, such as those pharmaceutical manufacturers turn out in great quantities.

Another problem is that of pain killers meant to give short-term anesthesis and local anesthetics administered by doctors and dentists. Professor Erich Rughheimer, chief anesthesiologist at Erlangen-Nuremberg University Hospital refuted the assumption that local anesthetics have no effect on driving ability. "Their strain on circulation and effect on the central nervous system remains for hours after intake," he says.

Misnomers for both patients and doctors are the *short-term* narcotics, since tests for four such drugs revealed that the user should not drive a car for anywhere between 12 and 24 hours after intake.

While the doctors emphasized that responsibility for adequate warnings and prevention of indiscriminate use of medication demand priority, methods have yet to be determined. Discussions ranged from legal responsibility on the part of doctors and patients, to voluntary use of judgement.



Darvon warning too soft

WASHINGTON — A parting salvo was issued by Joseph Califano against new warning leaflets on the dangers of propoxyphene (Darvon) distributed by the Eli Lilly pharmaceutical company and approved by the US Food and Drug Administration.

In one of his last acts as secretary of Health Education and Welfare, Mr Califano called for a Surgeon General's Advisory to Doctors that would directly caution them about the dangers of propoxyphene.

Earlier this summer, Mr Califano refused to ban the drug but called on doctors not to prescribe it unless absolutely necessary, and on patients not to ask for it.

Mr Califano said the new package inserts for doctors and patients produced by Lilly do "not adequately reflect my concerns." He said:

- The inserts do not inform the patient of the maximum recommended dose, or the dose level that will produce toxic effects, or the signs of drug dependency.
- The inserts do not reflect concern that Darvon is a dangerous drug whose use should be avoided. The insert for doctors says only that they should prescribe the drug judiciously and patients should be warned about using it together with alcohol.
- Some of the insert statements are disputable, especially the claim that a combination of propoxyphene and acetaminophen is a stronger analgesic than both alone. "I understand there is considerable dispute over whether, and the extent to which, this is true," Mr Califano said.

Mr Califano said that given the number of deaths associated with Darvon, whether suicidal or accidental, the subject merits careful attention by the Surgeon General.

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NEWS

Heavy use may cause lung damage

Paraquat - sprayed pot dangerous, says HEW

WASHINGTON — Smoke of paraquat-contaminated marijuana is likely to cause serious, and in some cases irreversible, lung damage if inhaled in sufficient quantities, the United States department of Health Education and Welfare (HEW) has concluded.

Joseph Califano

Lung damage from intermittent or short term exposure may be reversible, but frequent, high level exposure over a long period can result in fibrosis, outgoing HEW Secretary Joseph Califano said in a letter to Secretary of State Cyrus Vance. Marijuana grown in Mexico and sent to North America is being sprayed with the herbicide.

Mr Califano said it is not possible to know the extent of the danger — less than 1% of the samples confiscated by the Drug Enforcement Administration on the East Coast, Mid-west, and Pacific North-west, had been found to be contaminated, while more than 12% from the South-west was contaminated.

Last year, Congress prohibited US funds for spraying, if paraquat is likely to cause serious harm to health of marijuana smokers. However, paraquat spraying could continue if a suitable warning marker was used as well.

Mr Califano said an odorant, d-limonene-di-mercaptan (DLDM) is being tested but little is known about its possible toxicity.

Lee Dogoloff, of the White House Domestic Policy Staff, told **The Journal** the warning is now being considered by drug policy and state department officials. He said efforts to use markers "have run into all kinds of problems."

"These run from very technical problems with encapsulation to the problem that companies do not want to produce markers unless the government indemnifies them against any future action."

Mr Dogoloff pointed out that the present statute "does not allow a concept of relative harm. If we have to cut off the program in Mexico, what does that mean in terms of increased harm to additional marijuana users? Or, what is the incremental harm of paraquat-sprayed marijuana over unsprayed marijuana?"

Meanwhile, Mexican officials make it clear they are signatories to an international treaty requiring them to fight illicit drug production and trafficking and they will continue to fulfil their obligation with or without American aid.

Credit goes to TV for DWI drop

VANCOUVER — Video-taping of drinking drivers is credited with a 25% drop in impaired driving charges and a 40% drop in "not guilty" pleas in the town of Vernon, British Columbia.

As a result, the use of video-taped evidence is being expanded to five other municipalities: Burnaby and Richmond, which are suburbs of Vancouver, and Prince George, Cranbrook, and Saanich. Vancouver is expected to be added to the list as soon as formal municipal approval is obtained.

The tapes record drivers' attempts to perform physical sobriety tests. BC is the only Canadian province to allow their use as evidence, although some states in the United States do so.

The Vernon experiment, which started last year, has saved an estimated $41,000 in court costs.

Drinking drivers annually cause about 300 traffic deaths in BC.

Feds will aid BC heroin plan

VICTORIA — Federal health minister David Crombie has indicated his ministry will contribute financially to British Columbia's compulsory heroin treatment program.

After a meeting here with provincial health minister Bob McClelland, he told reporters he would be willing to fund "voluntary aspects" of the program and said he would be meeting with Mr McClelland in Ottawa in September to discuss the matter.

This would be a reversal of the previous Liberal government's policy of shunning the whole project.

Mr Crombie said BC has the worst heroin problem in the country and "we are therefore interested in participation with respect to the voluntary aspects of the program."

He said the federal government remains uncomfortable with the compulsory provisions, which allow a person judged to be an addict to be committed to a three-year treatment program.

"But we wouldn't want that to stand in the way of the federal government carrying out its responsibility."

David Crombie

Senate oks Kennedy's reform bill

WASHINGTON — A reform bill which would affect radically the speed with which new drugs could be put on the United States market, as well as taken off, has received a key vote by a Senate committee.

The bill has been worked out over four years by Senator Edward Kennedy and received unanimous approval of the Senate labor and human resources committee. It has now gone to the House commerce health subcommittee for action this month.

The bill would set up a system of post-marketing surveillance of new drugs, which would help spot early any unexpected side effects.

In addition, the bill would let the Food and Drug Administration (FDA) allow clinical use of drugs on a very restricted prescribing basis and limited to specific conditions. This would release drugs which would not be approved now because once they're on the market a doctor can prescribe any drug for any condition.

The FDA would be empowered to remove a drug from the market if it proved to be a serious danger to patients. Today the FDA can only ban a drug after it has proven it is an "imminent hazard" to health, which does not happen often.

FDA proposes drastic cut in diet drug production

WASHINGTON — A ban which would limit prescribing of amphetamines to only two medical conditions — narcolepsy and minimal brain dysfunction in children — is proposed by the United States Food and Drug Administration (FDA).

The ban would stop amphetamines being prescribed for obesity and would lead to an estimated 90% cut in production of the drug. A period of public comment, as well as a hearing, will be allowed by the FDA before final action is taken.

A statement by the agency said "amphetamines continue to be abused at a rate substantially higher than that for other drugs used in the treatment of obesity." In addition, amphetamines present a severe risk of "dependence and harmful effects" and alternatives are available that are equally effective but hold less risk.

'Decline in circumlocutions is abysmal failure'

By Wayne Howell

Once a year the Social Science Jargon Writers' Association (SSJWA) holds an annual conference. These conferences are usually lively affairs, and this year's in Montreal was no exception. It was, of course, a conference that no serious jargon writer could afford to miss, because the keynote speech was delivered by the renounced obfuscator H. R. Twillingham. Dr Twillingham, the genius who rescued "paradigm" from its obscure position in the dictionary between "paradichlorobenzene" and "paradisal" and made it into a household word, is a legend in his own time and a father figure to many young social science jargoneers.

Dr Twillingham had harsh words for the delegates. Jargon writers, he said, were becoming lazy and complacent. In his recent readings of books, manuscripts, and journals, he had detected a decline in circumlocutions, a fall-off in neologisms, and a general tendency on the part of the writers to use simple words when a little thought and effort would have resulted in something more incomprehensible.

He accused the SSJWA of resting on its laurels and avoiding bold new experiments. An example of this, he said, was the abysmal failure of the jargon writing fraternity to capitalize on and 'exploit the use of the noun "target" for the verb "to aim."

When a word breaks through the noun/verb barrier, it is a great moment in jargonizing, he said, a tide in the affairs of the SSJWA that must be taken at the flood. But where were the "targetizings," the "targetizations," the "dystargetizings," and the "non-dystargetizations?" Social science jargoneers were still using the breakthrough word in the most mundane way, as in "the program is targeted to minority groups." This, said Dr Twillingham, showed a failure of craft.

And there was more criticism to come: he quoted from the work of some of the prominent delegates and sarcastically remarked that it was intelligible to anyone with a grade 10 education; he heaped scorn on those delegates who deleted jargon words from manuscripts when faced with an intransigent editor ("where are your principles?"); and he even attacked the conference chairman (a painfully shy man best known for having coined the phrase "multi-variate modalities") for not following through on last year's resolution to create a special task force to come up with jargon pronouns and conjunctions.

It was a tough hard-hitting speech, but Dr Twillingham ended the address by saying there was no human being who loved the profession of jargoneering more than he did, that his words to the assembled fraternity had been spoken more in sorrow than in anger, and that he hoped they would stimulate discussion.

That they did: unlike some other annual meetings, when SSJWA delegates were known to slack off around the pool with cold gin concoctions, the workshops were well attended and there was much lively discussion about the future of social science jargon.

The Neologism Workshop, in an attempt to prove Dr Twillingham wrong, labored far into the night, eventually producing a particularly exquisite Latinized expression, "the targetum," to describe a group at which a particular program was aimed (targeted). When this word was presented to Dr Twillingham at the final banquet, the grand old man was deeply touched and there were tears in his eyes when he rose to respond.

"When I see what you bright young jargoneers can do when you put your minds to it," he said, "I have hope for the future of the SSJWA after all. For I know there are some of you out there who have not lost sight of our basic goal, which is to impress the reader rather than to inform him."

(Wayne Howell is an Ottawa physician and freelance writer.)

NEWS

Tolerance/dependence-an inverse relationship?

By John Shaughnessy

TORONTO — There may be an inverse relationship between tolerance to and physical dependence on alcohol.

Data from a study at the University of North Carolina, Chapel Hill, are not consistent with the hypothesis that the ethanol withdrawal syndrome is the expression of tolerance.

However, C. Abu-Murad and R. G. Thurman from the university's department of pharmacology, speculate that the observed reversal of tolerance might be essential for the expression of the withdrawal syndrome, suggesting a possible inverse relationship between tolerance to and physical dependence on ethanol.

In the study, male Sprague-Dawley rats were exposed to different concentrations of ethanol vapor (10 and 15/1) for various periods of time (0.5, 1, 2, 6, and 10 days). The degree of physical dependence on ethanol was assumed to be reflected by the severity of a subjectively scored behavioral withdrawal syndrome. Tolerance to ethanol was tested by measuring the concentration of ethanol in breath by gas chromatography at loss of righting reflex of the animal after an i.p. injection of ethanol.

In their presentation to the Third International Symposium on Alcohol and Aldehyde Metabolizing Systems here, the researchers reported that breath ethanol correlated linearly with blood ethanol. With all treatments, the maximum tolerance obtained was about 170%.

In addition, the proportion of rats showing signs of withdrawal from ethanol increased with the duration of treatment as well as the concentration of ethanol vapor inhaled. For instance, exposing 12 rats for 10 days to ethanol vapor (10 mg/1) produced signs of behavioral withdrawal in eight rats.

Tolerance was tested in all rats after termination of treatment as well as at the peak of withdrawal. The team found that withdrawing animals did not exhibit tolerance while non-withdrawing rats exhibited tolerance at least 50% higher than controls.

"It is difficult at this stage to put forward a satisfactory interpretation of these findings," said the team, "But it seems possible that the development and reversal of tolerance are a prerequisite to the development of dependence. Alternatively, tolerance to and physical dependence on ethanol might be dependent mechanistically but only linked temporarily."

"It's brilliant research Gilcrist, But can't you be more definitive than 'six rats went belly up and the other six didn't give a damn?"

CNS effects of alcohol and benzodiazepines

TORONTO — A comparison of the central nervous sytem effects of alcohol and benzodiazepines indicates they probably share certain neural mechanisms.

However, there is no evidence to suggest that alcohol interacts with the sites in the central nervous system that bind benzodiazepines.

According to researchers in the department of psychiatry at the University of North Carolina, Chapel Hill, current evidence implies that ethanol and benzodiazepines can effect similar changes in selected CNS functions suggesting the possibility of parallel neural mechanisms. To test this hypothesis, the team compared several prominent behavioral and neurochemical effects of ethanol, chlordiazepoxide, and diazepam.

Results of the comparison were presented to the Third International Symposium on Alcohol and Aldehyde Metabolizing Systems here.

The team found that chlordiazepoxide was approximately 1,000 times more potent than ethanol in impairing the aerial righting reflex, in depressing guanoisine-3, 5'-monophosphate, and in reducing ethanol withdrawal seizures in rats.

At "optimal doses" ethanol produced relatively greater stimulation of locomotor activity of mice than chlordiazepoxide, but was less active in "disinhibiting" shock-suppressed licking in water-deprived rats. Both ethanol and chlordiazepoxide facilitated the acquisition of shuttle box avoidance responding in rats. Only ethanol increased intertrial interval crosses.

The purported ethanol antagonists, fenmetozole and thyrotropin releasing hormone, antagonized the impairment of aerial righting reflex evoked by both chlordiazepoxide and ethanol.

In Vitro, ^{3}H-flunitrazepam was displaced from brain membranes by diazepam or chlordiazepoxide but not ethanol, and chronic diazepam or ethanol treatment — sufficient to produce physical dependence — did not alter binding.

"Therefore, benzodiazepines and ethanol share some neural mechanisms without competing with each other for ^{3}H-flunitrazepam binding sites," said the researchers. Members of the team were G. Frye, R. Vogel, R. Mailman, G. Ondrusek, C. Kilts, J. Wilson, R. Mueller and G. Breese.

Study casts doubt on alcohol tolerance/cross tolerance theory

TORONTO — Doubt has been cast on one of the widely held theories concerning tolerance and cross tolerance to alcohol.

In a presentation to the Third International Symposium on Alcohol and Aldehyde Metabolizing Systems here, J. M. Khanna, H. Kalant and A. D. Le said the "intriguing results" of one of their research projects challenge the generally believed concept that tolerance and cross tolerance, once produced, are sustained with chronic treatment.

"The results may raise the possibility that such processes are reversible even during chronic treatment, at least under certain regimens," said the team.

In the study, the researchers, from the University of Toronto's department of pharmacology and the Addiction Research Foundation of Ontario, fed adult male Wistar rats nutritionally adequate liquid diets providing 35% of the total calories as ethanol. Pair-fed controls received the same diet with ethanol replaced by sucrose.

At two, four, six, and eight weeks of chronic ethanol treatment, separate groups of rats were injected with a test dose of either ethanol (3g/kg) or pentobarbital (40 mg/kg). Rectal temperatures were determined prior to and at 30, 60, 90, and 120 minutes after injection.

The team found that the fall in rectal temperature after a challenge dose of ethanol or pentobarbital was significantly lower at two and four weeks in the ethanol rats than in the controls, whereas at six and eight weeks of chronic ethanol treatment, the groups did not differ significantly in hypothermic response to either ethanol or pentobarbital.

A similar patter of results was obtained when ethanol-induced sleep was compared in ethanol treated and control rats.

Poster wins award—and wrath

LONDON — There are signs the persuasive skills of health educators are achieving penetration: an award winning "sensible drinking" advertisement here has stung one drinks firm into angry reaction.

The row began when Stuart Kershaw, managing director of the leading wine and spirit producer, Seagrams, wrote to the director general of Britian's Health Education Council (HEC), Alastair Mackie.

Mr Kershaw complained that the HEC's latest advertisement used in the Northeast of England had "sexual overtones," and should therefore be discontinued.

It draws attention to the possible effect that alcohol may have on potency.

Mr Mackie was not, however, impressed by Mr Kershaw's claim. He noted the advertisement had been named the best black and white advertisement of the year by a major advertising trade magazine and also received other significant praise.

"I cannot give you any assurance about this advertisement except that we shall continue to use it whenever it is suitable,"Mr Mackie went on. He added that far from carrying sexual overtones, the advert stated a physiological fact. Moreover, Seagrams had in the past used advertising for its products which were of a sexual nature.

Mr Kershaw responded by reminding Mr Mackie that his company and the alcohol industry as a whole were making active efforts to increase the understanding of alcoholism although it was a problem which affected "only a minute percentage of the population in the United Kingdom."

Toronto research

Drug tolerance theory gains more support

TORONTO — Research conducted at the University of Toronto adds weight to the theory that tolerance and cross tolerance among drugs develop to drug effects rather than to drugs per se.

In the study, by A. D. Le, J. M. Khanna, and H. Kalant from the university's department of pharmacology and the Addiction Research Foundation of Ontario, adult male Wistar rats were fed chronically a liquid diet providing 35% of the calories as ethanol (12-14 g/kg ethanol daily), while pair-fed controls received the corresponding diet with alcohol replaced by an equicaloric concentration of sucrose.

Rectal temperatures, after test doses of ethanol or morphine, were measured in several groups of rats at various times during chronic ethanol treatment.

At the Third International Symposium on Alcohol and Aldehyde Metabolizing Systems here, the team reported that the fall in rectal temperature after a challenge dose of ethanol (3.0 g/kg) was significantly lower in the alcohol group than in the controls, indicating tolerance to ethanol-induced hypothermia as a result of chronic ethanol treatment.

The rats also developed cross tolerance to the hypothermic effect of morphine (15 and 30 mg/kg), whereas no cross tolerance to the hyperthermic effect of morphine (5 mg/kg) was seen. Administration of morphine (30 mg/kg), whereas no cross tolerresulted in tolerance to morphine hypothermia and also cross tolerance to ethanol-induced hypothermia.

"These studies fit with our hypothesis that tolerance and cross tolerance among drugs develop to drug effects rather than to drugs per se," said the team. "Therefore drugs sharing a common effect, even by different mechanisms, might show cross tolerance for that effect."

NEWS

Cannabis control options-a major new study

By Alan Massam

LONDON — The "quite massive" deployment of resources by the state to enforce the ban on cannabis in the United Kingdom "cannot be said to have achieved its objectives."

Moreover, "on all the available evidence, both consumption and illicit supply have increased greatly over the past 10 years. And it is an open question whether or not this trend will continue.

"At the same time, enforcement (of the cannabis control laws) has had a number of undesirable social consequences, the most important being that considerable numbers of young people of good character who would not otherwise have done so have found themselves at odds with the law."

This is the background against which options to the present system of control of the drug have been considered in a major new report published here in August by the Institute for the Study of Drug Dependence.

The study emphasizes, however, that it does not seek to recommend whether

'Our aim has been to be as objective as possible . . .'

cannabis should be more, or less severely controlled — as have other reports on the drug.

It concerns itself only with the relative *feasibility* of four options:

1 Retaining the present complete illegality of cannabis but modifying the maximum penalties imposed on people caught in possession;

2 "Decriminalizing" possession and small-scale cultivation of cannabis for personal use while retaining heavy penalties on trafficking and supply;

3 Making cannabis legally available through specially-licensed outlets;

4 Making cannabis legally available without restrictions.

"Our aim has been to examine these alternatives as objectively as possible and thus provide the necessary groundwork for an informed discussion of how best to handle the problems of cannabis use in Britain," the authors state.

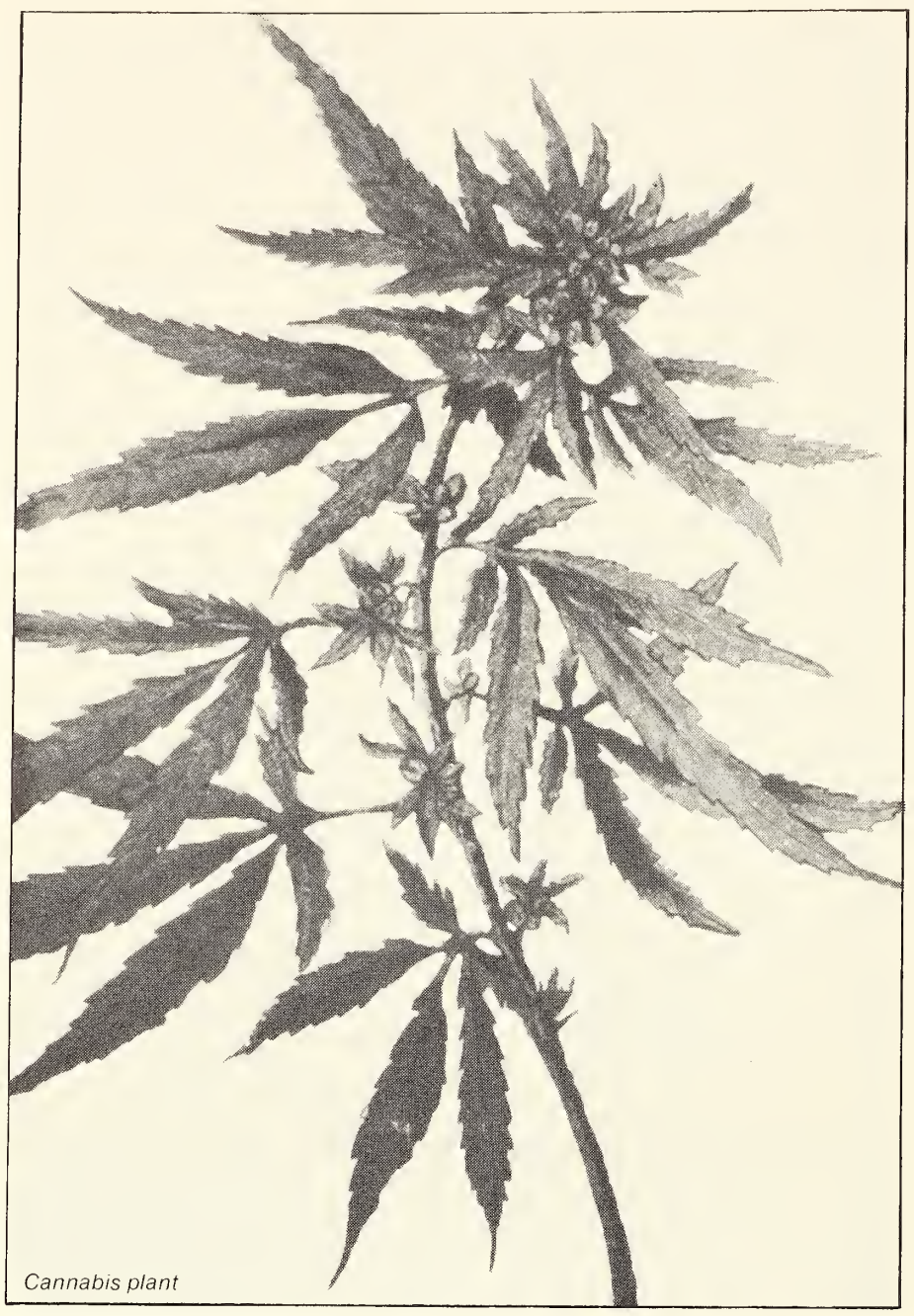
Describing the options, the report notes that retention of the present prohibiting system, but with changes in maximum penalties, would only amount to a "new option" if the changes were drastic.

On Option 2, it says that the aim of decriminalization is to remove the stigma of criminality from cannabis use by the individual, but at the same time to prevent commercial exploitation.

Licensing (Option 3) would aim to regulate use, consumption, or behavior, permitting moderate use by adults without increasing availability unduly; discouraging excessive consumption; and reducing the attractions of the illicit market by providing a legal source of supply.

Legalization (Option 4) is defined as the removal of prohibitions on cannabis although all forms of control might not be immediately abolished.

Alan Massam



Cannabis plant

The report stresses that as the UK is a party to the Single Convention on Narcotic Drugs, she must comply with international requirements for the control.

OPTION 1: Changes in maximum penalties.
Under this heading, the authors agree that the greatest deterrent to cannabis use is the social disgrace and likely adverse effects on career prospects resulting from a drug conviction. It would seem, they add, though the evidence is meagre, "that present maximum penalties for simple possession are higher than they need be and could be considerably reduced without losing the deterrent effects."

'It would seem present maximum penalties are higher than need be . . .'

OPTION 2: "Decriminalization."
The report observes that the cannabis plant can be grown without much difficulty in the British climate and that one or two substantial plants grown in a garden, or probably twice that number grown on a balcony or indoors, "would produce a crop sufficient to supply five marijuana 'joints' per week, each containing five milligrams of THC." This would meet the regular annual needs of a moderate user.

"Since cannabis, like any other crop, has to be harvested when ready, our urban people growing for their own consumption would be likely to have in their possession quite a substantial amount of plant material at the time of harvesting, say 400 grams produced from four plants.

"It is not at all easy to see how possession in such circumstances could be distinguished from possession of similar amounts for the purposes of trafficking. Indeed, this consideration alone would seem to rule out the idea of a quantitative dividing line for possession in private. This is one of the difficulties of decriminalization that seems to have escaped notice by its advocates."

The report stresses that the control feature of decriminalization is that possession of small amounts of cannabis for personal consumption ceases to be a criminal offence and it quotes one judge in the US State of Oregon (where "decriminalization" of cannabis was pioneered) who has referred to the "farce" of current state marijuana laws under which possession of just under one ounce may result in a maximum fine of $100, while possession of just over one ounce subjects a person to a possible sentence of 10 years imprisonment.

'The group concluded the poisons-type system might be capable of adaptation . . .'

OPTION 3: Licensing Systems.
The report says that the purpose of a regulatory system for cannabis should, in the view of the authors, be to make the drug legally available with the least possible increase in consumption.

It adds: "After examining the machinery for controlling four types of substances (tobacco, alcohol, controlled drugs, and poisons) that pose certain common problems, the group concluded that of these only a poisons-type system might be capable of adaptation to meet the stated objectives."

Special outlets termed "authorized sellers" would be licensed for the sale of cannabis and restricted to a limited number in each area.

The purchaser would have to give reasonable proof of his identity and place of residence, and the seller required to enter the sale in a register and give a receipt which could be shown as proof of lawful possession.

'The purchaser would have to give reasonable proof of identity and place of residence . . .'

"Such a system would make it possible for people to purchase cannabis legally but without opening the door to unrestricted consumption," the authors state.

Furthermore, if a stricter form of control is postulated, this might be achieved by means of a rationing or quota system.

The authors recall that highly successful schemes for rationing food and clothes operated in Britain during the war.

Everyone could obtain a small ration of sweets or chocolate by handing over a coupon from their ration book.

"It would seem feasible to apply this type of system with necessary modifications, to cannabis," the authors conclude.

On the organization of the supply of "legal" licensed cannabis, the report rejects the notion of a state monopoly on the grounds that no British government would want to assume responsibility for supplying a "pleasure drug" that "at best carries no benefit for health and whose long-term effects are still uncertain."

It suggests, instead, that the tobacco or alcohol manufacturers might be prepared to supply cannabis. "We understand there are no insuperable technical problems in producing either a cannabis cigarette or a palatable cannabis drink, both with predetermined THC content," the authors note.

OPTION 4: Legalization.
The report says that an estimate of cannabis consumption following legalization must be highly speculative, but on experience with tobacco and alcohol, it would be surprising if consumption did not increase substantially.

'The habit is well-established and unlikely to disappear . . .'

"If it is correct that four million people in Britain had smoked cannabis up to 1973 (national and local surveys estimate) the habit is well established and unlikely to disappear," the authors conclude.

"Legalization could hardly fail to provide a sharp impetus and encourage many more people to experiment though this does not mean that they would continue to use. Much would depend on unpredictable changes in taste and fashion which, in turn, are heavily influenced, in a mass market, by advertising and the media as well as the attitudes of ephemeral cult figures such as pop stars."

Cannabis Options for Control. Published by Quartermaine House for the Institute for the Study of Drug Dependence (Kingsway House 3, Blackburn Road, London NW6 1XA, Tel. 01-328 5541) at £3.50. Chairman of Study Group, Dr T.H. Bewley, Secretary and editor, Mr Frank Logan.

Program will focus on drug-troubled workers

By Donald Gregory Bastian

TORONTO — Cathy Dixon says her new job as director of the Addiction Research Foundation's (ARF) Provincial Resource Centre for Employee Assistance Programming is the "front-end activity" of the foundation's work in the EAP area.

"When anyone with a drug or alcohol problem is referred from a company to the foundation's treatment centre, there needs to have been a lot of work done in the company prior to the referral," Ms Dixon said.

In the newly-created centre and position, she plans to focus on helping management get clear on how to identify employees with personal and work problems, and how to refer them for counselling — addiction counselling, in the foundation's case.

For the past year, she has been program head of ARF's Treatment Program for Employed Problem Drinkers. Companies refer employees with alcohol and drug problems to this program.

"The foundation plans to mount a concentrated effort to see if it can see some of the fruits of EAP (employee assistance program) work. There has been a lot of promise in EAPs, but now it's time to see if the results measure up," she said.

Another target of the foundation is to expand the percentage of the Ontario workforce that is covered by a policy that allows for referrals to treatment centres for drug and alcohol problems.

At least 8% of the Ontario workforce is currently covered, and there is a small percentage of informal referrals from companies that do not have such policies.

Ms Dixon said a steady 10% of referrals to the foundation's treatment centre are women, in spite of indications from surveys and studies that more and more women have drinking problems.

"This may be because the kinds of organizations interested in the program are male-dominated, or perhaps because women may be more efficient in covering up their drinking."

The emphasis of the foundation's approach to EAPs is that the supervisor of an employee treat a detected problem in the context of work.

"The supervisor should tell the employee that his or her job is not going well, that something's not right on the job. Then it's up to the company physician or employee counsellor to try to find out why and refer the employee to the appropriate kind of counselling — whether credit, family, or addiction counselling."

She said the supervisors or employees need to be alert to absenteeism as a possible indication of alcohol or drug abuse. The figures can range as high as a month of absenteeism total out of one year's work.

Another sign is a noticeable difference between a long-time employee's former work habits and new ones that are out of character.

Ms Dixon is well-prepared to shift her attention from employees referred to the treatment centre, to company management's role in referring those workers.

Before joining ARF six years ago as a social worker, she worked as an employee counsellor in a large Toronto insurance company. Her job was to set up a counselling referral system and to teach managers to develop skills for dealing with employees on a personal level.

"These managers had become very proficient in the area of their technical skill, but had never had the chance to develop skills to deal personally with the people that worked for them."

She said about half the problems of employees in that company turned out to be work-related. "I know it is obvious, in a way, but I never realized first-hand the significance of work to people. If you have problems at home, you bring them to work; if you have problems at work, you take them home."

Trained in social work at the University of Toronto, Ms Dixon was one of the first women street workers in Toronto, working with groups of adolescents who were in trouble with the community.

She said she sees the base of her job being the "heavy groundwork" laid by ARF in developing its EAP program.

Her first step will be to discuss with people already involved in EAP work at the foundation just what they feel are the strengths and weaknesses of the program.

She will then formulate the overall plan and policy of ARF in EAP work for the coming year.

And she said the primary responsibility of the Provincial Resource Centre for EAPs will be to make sure people doing the front-line work have the tools and resources they need.

The Resource Centre was established on the basis of recommendations by the ARF's Task Force on Employee Assistance Programs.

That task force deemed the foundation's principal roles in EAP should include facilitating development of effective EAPs throughout Ontario; training staff who will assist organizations in initiating, conducting, and monitoring EAPs; and conducting research designed to evaluate and improve the effectiveness of EAPs.

It envisaged the resource centre as a "centre of excellence, leadership, and specialized knowledge in EAP matters."

Drugs may alter sperm/semen

Birth defects traced to fathers

By Werner Bartsch

TORONTO — A Vermont pharmacologist believes he has helped launch a "major new field of research" by demonstrating how drug-caused birth defects may be traced to the father.

Lester Soyka and his associates at the College of Medicine, University of Vermont, gave methadone to male rats, then let them breed with drug-free females. During four years of experiments, the results were dramatically consistent: smaller litters, lower birth weights, and an excessive number of deaths among the new-born rat pups.

Preliminary experiments with the painkiller propoxyphene (a chemical analogue of methadone and widely used as Darvon) and high doses of caffeine, yielded similar results.

Dr Soyka notes that these experiments are among the first to catalogue how males may contribute to birth defects. "There's all kinds of studies which look at how chemicals affect pregnant females but next to nothing on the male's role."

But Dr Soyka is cautious about what his experiments prove. "It still needs to be established," he said in a telephone interview from his office at the university, "if this is a generalized phenomenon." He wonders if all drugs taken by males will affect the offspring. As well, "there's the old question of extrapolating from mice to men."

However, he is quick to add: "In light of the fact there are very few answers to causes of infertility and birth defects, it would be reasonable to ask whether observations made in animals wouldn't be applicable to man.

"In one of the few studies on drugs transmitted in the semen of humans, concentrations of methadone were found which were higher than those in the blood stream.

"Dr Robert Anderson of Illinois has done studies with alcohol-treated male mice and obtained the same results that we did.

"There is also a case of a child born with signs of fetal alcohol syndrome where only the father was a heavy drinker," he says.

Dr Soyka would like to try to pinpoint what caused the pups to die. As yet no one knows how drugs transmitted by the male do their damage. Dr Soyka speculates that the sperm or seminal fluid might be altered or that the female's reproductive cycle is affected either by the drugs she receives from him or by his changed behavior.

"What your mother doesn't understand is that I ENJOY drinking."

Vancouver wants compulsory treatment for alcoholics as well as heroin addicts

VANCOUVER — This city is calling on the provincial government to set up a compulsory treatment plan for skid row alcoholics, similar to the province's controversial heroin treatment plan.

Backing the idea are liberal politicians. That's ironic enough — but bucking it is Bert Hoskin, chairman of the British Columbia Alcohol and Drug Commission, the author of the compulsory heroin program.

Vancouver city council's community services committee has voted to urge the province to pass legislation allowing a judge to commit chronic alcoholics to a 90-day treatment program on the advice of two doctors.

Community worker May Gutteridge told the committee the proposed program is desperately needed. Skid row activist Bruce Eriksen, president of the Downtown Eastside Residents Association, said his organization supports the plan because lives are more important than a few weeks of freedom.

And left-wing alderman Harry Rankin, chairman of the council committee, said the program would save tax dollars. It costs almost $400,000 a year to pick drunks off the street, dry them out, and then dump them on the streets again. Some alcoholics get treatment, but in hospital and psychiatric facilities that are much more expensive than the proposed program, he said.

However, Mr Hoskin urged the committee to give up the idea.

"It's not workable in the form it's written; the ramifications of this program are tremendous."

One problem would be getting a drunk in reasonable condition to appear before a judge within 24 hours of being picked up, he said.

Health minister Bob McClelland said the province's first priority remains a detoxification centre. The centre has been delayed by the city's rejection of two proposed sites, he said.

Patients hooked

TORONTO — An addiction apparently created by their physician, has been identified among some Massachusetts patients.

The addiction is to one-page health letters which Robert M. Soule sends out long with his bills.

Some of the patients, it appears, are hooked. One woman said she was thinking of not paying her bills since she would stop receiving the letters once her account was paid up.

Dr Soule, who practises in Melrose, Ma, has been sending the letters out for the past few years, according to *Medical World News* (Aug 6). He deals with subjects ranging from arrhythmia to ulcers to nephritis. Some are illustrated with cartoons, occasionally drawn by Mrs Soule. Others, like the letter on nephritis, present a disease in terms of human history and then outline progress in treating it.

Dr Soule got the idea from a report in a medical journal about another physician doing the same thing. His own theory: "I think the more patients understand what to look for and how to manage their problems, the more we can work together to prevent disease."

Aware that medical information can be easily misinterpreted, he says he always tries to write the letters in simple language and be as optimistic as possible.

As for the woman thinking of not paying her bills: "I told her she could come into the office any time to pick them up but please not to stop paying her bills or I'd go ont of business."

NEWS AND COMMENT

Clonidine works in methadone detoxification

By Harvey McConnell

PHILADELPHIA — A successful detoxification of all 30 patients on methadone maintenance was achieved with the anti-hypertensive clonidine in a trial at the Connecticut Mental Health Center, New Haven.

Maurice Gold, in a report to the annual scientific meeting here of the Committee on Problems of Drug Dependence, said followup on some of the patients suggests "a large number of patients can be detoxified with clonidine and they can become opiate and methadone free."

Dr Gold said that in a previous trial clonidine had been used on an outpatient basis and there had been problems with dosages and some of the addicts remaining drug free.

In the most recent trial, 30 patients were given clonidine at the rate of 17 micrograms per kilogram per day for 10 days, and then decreased doses for three days before treatment was completed on the 14th day.

All of the patients had been in a methadone program for at least six months. They had been addicted to opiates or methadone for up to 15 years on average. The average methadone dose was 40mg a day.

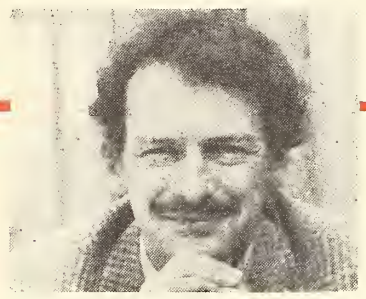
All patients were interested in withdrawing from methadone and gave informed consent for the trial. All had a history of unsuccessful attempts to withdraw.

Clonidine produced a rapid and significant abolition of opiates withdrawal signs and symptoms. There were significant drops in systolic and diastolic blood pressure as expected.

Dr Gold said: "In many cases clonidine administration produced such dramatic relief of subjective distress that the patients bordered on euphoria — with some important differences. Nervousness decreased significantly and there was also a significantly reduced irritability."

All of the addicts felt they were kicking the habit. The only side effect were complaints of difficulty in falling asleep among 21 patients.

Dr Gold said that clonidine administered in a hospital setting offers an additional treatment option for addicts.



GILBERT

'The emergency in our oil supplies provides a case for the recruitment of substance abuse experts to the business of reducing energy use. Would they have anything to offer?'

ENERGY DEPENDENCE:

Does science have a cure?

By Richard Gilbert

We are but an intimate part of the delicate skin of a planet. Like the cells of an epidermal carcinoma, we are reproducing our kind at a rate that endangers the skin's other constituents. As we proliferate, we poison the earth's rind with the effluent of our industry. Worse, we gluttonize resources that, unlike those of human skin tissue, are largely irreplaceable. Worst of all, we gobble up energy — energy that fuels our breeding, our polluting, and our gluttony.

The Energy Analogy

It has become fashionable to talk of dependence on energy as though energy were a drug. "Some scenes from a nation writhing in the grips of gasoline withdrawal:" began a June 29, Toronto *Globe and Mail* editorial about United States oil shortages. On June 24, the *Toronto Star* had quoted a Brooklyn pump attendant as saying about some of his customers; "They're just like junkies. They've got to have their gasoline." On July 7, an article in the same newspaper talked about "the lone consolation" of Canadians, which is that "we can watch on television as Americans go through the agonizing withdrawal from oil several years before us. So at least we'll know what personal traumas lie ahead."

The Journal is not immune from this analogizing. In August, a report from New Zealand described a proposal to have drinkless days that would parallel the carless days in prospect for that country. In the same issue, columnist Dr Wayne Howell wrote about "the kind of violence that withdrawal (from gasoline) might lead to." He described paranoid fantasies that give way to delusions of grandeur: "America would get its fix from new technologies. And, if that didn't work, there was always the 82nd Airborne Division to make the producers listen to reason . . . ."

Drug Wars

Wayne Howell's satire may be just a bit too close for comfort. Like the alcoholic who plots a raid on the liquor store, the US seems to be planning an invasion of the Middle East. "US plans strike force to protect oil supplies," "Pentagon ponders landing the marines in the Mideast — just in case," ran recent *Toronto Star* headlines.

A friend suggested to me that the forthcoming oil wars will have their historical parallel in the Opium Wars of the 19th century. The analogy is not exact. Britain was trying to force opium on the Chinese who, in 1839, resisted by banning imports and burning British-owned stocks of the drug stored in Canton. The analogy would be exact if OPEC nations were now forcing oil on the US, threatening military action if none were accepted. In reality, the oil-producing countries are doing the opposite. Sensitive to the finite nature of their valuable resources, they implore North Americans to use less oil, not more.

Therapy for Abuse

Conservation is indeed the only rational course of action. Perhaps we can learn lessons about relieving our energy dependence from our experience in reducing other kinds of substance abuse. Indeed, faced with the cosmic consequences of our general excess, it may seem picayune to puzzle longer over immoderation in the use of drugs. The emergency in our oil supplies provides a case for the recruitment of substance abuse experts to the business of reducing energy use. Would they have anything to offer?

One lesson that could be learnt is that individual therapy for substance abuse is expensive and largely ineffective. Self-help groups seem just as useful, easier on the national pocketbook, and possibly more fun. If an energy glutton insists on personal treatment, some kind of behavior modification might be advised. A few successful applications to energy use have already been reported in the scientific literature. The results suggest that exhortation to save energy, commendation for doing so, and information about the consequences of particular conserving actions, can all play a part in reducing individual energy consumption.

As with alcohol use, however, local efforts are likely to be of little consequence in curbing a national appettite for energy. Experience with drugs suggests two useful strategies for action on the broad scale: negative advertising and price escalation.

Promote Parsimony

The issue of drug advertising is complex but it's reasonable to agree with suggestions in the 1979, US Surgeon General's report, *Smoking and Health*, to the effect that cigarette advertising has little effect on overall cigarette consumption whereas negative advertising can reduce cigarette use.

This view is consistent with a recent Canadian study of the impact of advertising alcoholic beverages on consumption, by Jacques Bourgeois and James Barnes.

The data on drugs and advertising, imperfect as they are, nevertheless suggest a strategy useful to a government that wants to reduce its people's energy use. Each advertisement for a product could be surcharged according to the energy cost of using the product, and the proceeds devoted to advertising that stresses both the urgent need for energy conservation and the horror that will ensue if we continue in our present ways.

A Modest Step

The data on alcohol price and per capita consumption are much better than those on advertising. Alcohol researchers, particularly at the Addiction Research Foundation of Ontario (ARF), have demonstrated convincingly that the alcohol use of a population varies inversely with the relative price of alcohol, ie, the more alcohol your surplus cash will buy, the more you will drink, other things being equal.

Moreover, an ARF survey has shown that most Ontario drinkers would be willing to pay more for alcoholic beverages if the long term result of higher prices would be a decrease in the prevalence of alcoholism.

Senator Hayakawa of California was quoted last November in an article by Alan M. Schneider in the prestigious journal *Science* as saying: "I do not believe a gasoline tax proposal will achieve the objective of conservation . . . . I believe a majority of Americans will continue to buy gasoline regardless of price." On the contrary, Schneider's econometric analysis led to an estimate that the elasticity of US gasoline consumption is -0.2054, meaning that for every 1% *increase* in gasoline price there is a 0.2054% *decrease* in gasoline consumption. He concluded that increasing gas prices by 5¢ a year until 1988 (in constant cents) would reduce consumption by 14%, which amounts to an average decline of 1.3% a year.

As I see it, much greater reductions in our energy use are both necessary and possible. North Americans could aim to *halve* their per capita energy use during that next 10 years, which would do no more than bring it in line with *present* European levels, which are themselves too high according to some commentators. Our experience with substance abuse could play a large part in helping reach this goal. Achievement would represent no more than a modest step towards ensuring the continuation of our species and the other life on this planet.

Next month: Why people smoke.

People most likely

CINCINNATI — A survey of more than 85 studies dealing with who's at risk for addiction leads to only two major conclusions, according to Ann Blankenhorn, alcoholism consultant, Central Community Health Board here.

"Conclusions derived from the studies indicate a relationship between substance abuse and inability to form personal relationships which are satisfying," she said. "These studies also imply that people who feel incompetent to cope with their life's problems also are inclined toward substance abuse."

One problem is that almost all of the studies measure the differences between adolescents who are abusers, and those who aren't. "This does not allow for the effects of substance abuse on the individual."

Also, long term studies generally show an increased incidence of psychosocial problems, without really getting at the pattern of personality characteristics involved. It is difficult, however, she said, to quantify such terms as "lability," or "lack of attachment to parents," "irritability," or "fearfulness." Also, there's a lot of personal judgment involved in applying such labels.

She suggested that instead of applying judgemental tags, it might be more productive in future studies to examine some of the behavior involved, such as court involvement, truancy, assault, running away, and early initiation into substance abuse.

Yet even in this, there's a pitfall in that some of these behaviors "are expected of adolescents, and whether they are extreme behaviors or not is not clear. Also, these studies refer to the patterns of those who begin substance abuse in adolescence, and say little about those who begin abuse in adulthood."

Bishop Charles Henry Brent (1862-1929) - A retrospective

'That damned opium mess has started again'

By Karin Pargas

TORONTO — A Canadian Anglican priest who has been dead for 50 years is being remembered this year by officials and leaders in the drug abuse field all over the world.

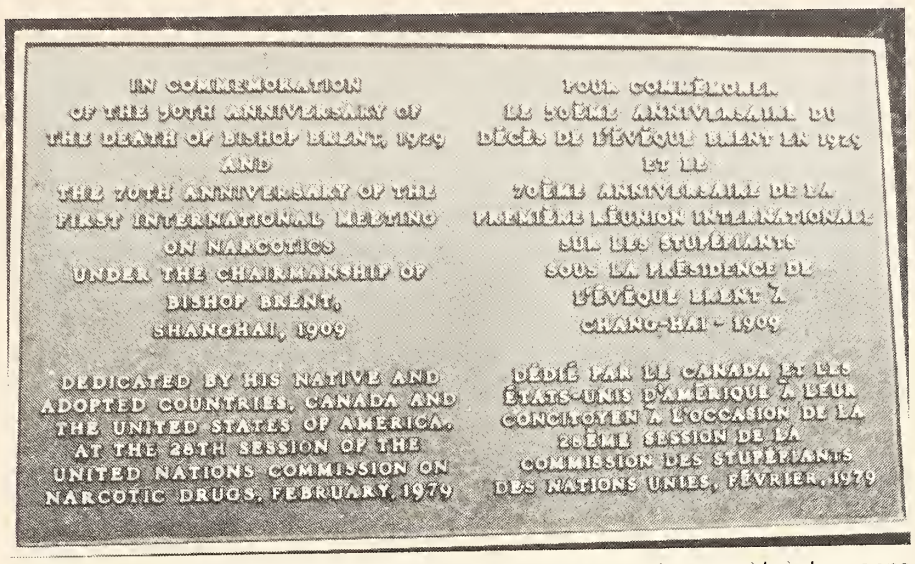
In the early 1900s, Charles Henry Brent set about organizing international collaboration as the only really practical means of drug control, and laid the foundation for the accomplishments achieved in reducing and, in some cases, eradicating the legal production of opium.

Born in Newcastle, Ontario, in 1862, Bishop Brent is being commemorated this year and next in Canada, his birthplace; in the United States, where he accomplished what others could not in a poverty-stricken area of Boston; in the Philippines where he worked as a missionary to eradicate the miseries of opium in the people; and, specifically, Switzerland, his final resting place and the country where officials gather annually for the meeting of the United Nations Commission on Narcotic Drugs.

Donald M. Smith, senior scientist, International Health Services, Canada, and chairman this year of the UN Commission on Narcotic Drugs is involved in events both to mark Bishop Brent's work and to feature the 70-odd years since the first commission on the international control of narcotics met in Shanghai. Bishop Brent presided.

In a speech prepared for the United Nations Economic and Social Council (ECOSOC) Dr Smith said: "Much has been accomplished in the last 70 years. Then, it was regarded as legitimate for national governments to insist on their prerogative of exporting narcotics to other countries for sale to addicts. Times, fortunately, have changed due to international action over the years . . . and slowly but surely all legitimate production of such substances has been put under strict international control for medical and scientific purposes only . . ."

Legal use of opium by addicts in the first decade of this century was not limited to China as is widely believed. Although importation of opium into China was banned as early as 1800, importation from India continued to escalate unchecked throughout the 19th century. The United States imported more than 700,000 pounds of opium for its addicts in 1907. It was in this climate, and in the Philippines, that Bishop Brent learned first-hand of the ravages of opium abuse.



The commemorative plaque above was placed at Bishop Brent's graveside in Lausanne, Switzerland by Canadian and United States delegations to the United Nations Commission on Narcotic Drugs in a special ceremony last February.

Roosevelt impressed

The Philippine Islands, under Spanish rule, had kept the price of opium too high through government monopoly for the average citizen to enjoy. Under US domination, the situation changed. The Philippine Commission, legislative power at the time, sought to deal with the opium problem by creating an opium monopoly.

As a missionary, Bishop Brent studied the problem and was appointed a member of the opium investigation committee. The committee came to the conclusion that no successful combination of revenue and restriction could be made and Bishop Brent became convinced that only by international agreement and action could anything be done.

His appeal to US President Theodore Roosevelt in 1906, urging the president to take the lead and call an international conference to consider the opium problem as a world phenomenon, impressed Mr Roosevelt, and resulted in the first International Opium Commission held at Shanghai in 1909.

It was one of the first times representatives of the world's nations had met to discuss a common problem and then return to their own countries to formalize local action.

A second international conference was held in The Hague in 1911. Bishop Brent was chairman of the US delegation.

The Bishop saw opium addiction as both a social vice and a form of moral corruption. Sickened that commercial aspects of opium trade should outweigh humanitarian considerations, he attempted to "arouse the conscience of civilized nations to a social evil of international dimensions."

He became involved in other duties at the time of the outbreak of World War I, but reentered the fray of the opium problem several years after peace had been declared. Less than eager to attend the post-war meetings on opium, he noted in his dairy: "That damned opium mess has started up again. We are expected to go to the assembly of the League sailing a week from tomorrow. I have other things to do besides trot to and fro across the Atlantic for the government." But, a telegram from the US Secretary of State was almost an order to attend; Bishop Brent was appointed representative of the US to the advisory board of the League of Nations on narcotic drug control.

This meeting was essentially a planning session for subsequent meetings in the fall of 1924. The first was to be composed of delegates from eight nations where opium smoking was still allowed under documents drawn up at the 1911 conference at The Hague. Agreement within this smaller group appeared necessary before arrangement of the second conference of delegates from 40 nations took place.

Human degradation

(Last year marked the 50th anniversary of the entering into effect in 1928 of the International Convention on Opium of 1925 which set up the Permanent Central Opium Committee, the predecessor organ in the League of Nations of the International Narcotics Control Board in the UN. This committee met for the first time in 1929. Thus, 1979 is the 50th anniversary for this body as well.)

Bishop Brent carried his weight against opium virtually to the grave. His health had been taxed by life in the tropics, and so much international travel, but he found energy to become bishop in charge of the American Episcopal churched in Europe from 1926 to 1928. In March, 1929, only two weeks before his death, the Bishop reiterated his conviction about opium to the US president. "Restrict manufacture as you may, so long as the raw product is available, our country as well as other countries will be flooded with contraband heroin and morphia."

His words were an astute prophecy for the future, as Dr Smith notes: "Although diversion from licit sources is under control internationally due to these efforts, we are left with the tremendous problem of the illicit traffic.

"A look back into the past like this enables one to stand back and examine how the phenomenon arose in the cultural context of the times. Whatever one's judgement on the approaches to the problem, it is still, fundamentally, a question of human degradation, of slavery to chemicals . . . which the cultures involved cannot handle."

Asthma patients at risk in smoky bars, discos

NEW ORLEANS — Smoke from others' cigarettes may precipitate asthma attacks in susceptible individuals, Southern Illinois University Medical School investigators reported at the American Academy of Allergy meeting.

While this problem has often been reported by asthmatics, it has never before been systematically studied.

J. F. Bolin, associated with the university's Clinical Allergy Program, tested 10 non smoking asthmatics and 10 non smoking controls in a closed chamber where they were exposed to sidestream smoke given off by a cigarette-smoking machine.

All the subjects experienced equal eye and nasal irritation, and increased blood concentrations of carboxyhemoglobin, which hampers normal respiration. But the asthmatics also showed a significant decline in lung function during tests given at 15-minute intervals.

"Although we cannot say what the mechanism is, these preliminary studies imply that asthmatic patients confined to closed areas where there is significant exposure to cigarette smoke are at risk of having bronchospasm," Dr Bolin told The Journal.

"We found that within an hour period of exposure to cigarette smoke in concentrations which you would find in a normal tavern or discotheque, the asthmatics all had significant falls in their pulmonary function tests, whereas the controls did not."

Dr Bolin plans more extensive studies on the effects of passive smoking on asthma, as well as on chronic bronchitis and emphysema.

Blood fat test tells alcohol tale

DALLAS — The alcoholic may lie about his drinking but his blood will tell the truth.

Specifically, said Joseph J. Barboriak here, a certain kind of fat found in his blood shows whether an individual is an alcoholic. It will also reveal the one who backslides.

Dr Barboriak said the incriminating blood fat is high density lipoprotein cholesterol (HDLC).

"Our findings show that a considerable proportion of alcoholics have significantly higher HDLC levels, suggesting that this relatively simple test may be of help in diagnosis of this condition," he told the American Societies for Experimental Biology annual meeting here.

Dr Barboriak added that a simple test has been greatly needed.

"Chronic alcoholics frequently use medical help for diseases which may be associated with or aggravated by alcohol abuse.

"Development of a test which would either confirm or exclude the suspicion of chronic alcoholism would be of help in proper diagnosis, in planning of appropriate treatment, and in checking on compliance with suggested therapeutic measures, such as abstinence from alcohol."

Dr Barboriak is at the Wood Veterans Administration of the Medical College of Wisconsin.

Dr Barboriak said he reached his conclusions about the advantages of performing this relatively simple test after measuring HDLC levels in the blood of 62 men and 24 women who were chronic alcoholics entering a detoxification program. Their values were compared with those of 24 age-matched men and 20 women who were not alcoholic.

Also, in some of those who were alcoholics, the tests were done repeatedly to see whether the abnormally high values would return to normal.

Along with this test, other tests usually associated with alcoholism, such as the SGOT, which measures enzymes released by damaged livers, were also done.

In the alcoholic group more than 2/3 of the men and 90% of the women had HDLC levels which were higher than the average value for the corresponding control groups. The HDLC levels usually returned to normal in about two weeks when drinking was stopped.

"Interestingly, in four of the alcoholics the HDLC levels were very low, much lower than seen in normal individuals," Dr Barboriak added. "The circulating liver enzymes were elevated. However, the changes in their levels did not correlate with the changes in the HDLC levels, indicating that each represents an independent reaction to excessive drinking.

"These findings thus indicate that abnormally high blood HDLC levels in patients suspected of alcohol abuse may be used as a confirmatory test. Abnormally low HDLC levels were associated with grossly abnormal hepatic function tests, and thus may indicate acute liver damage."

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Moral entrepreneurs crusade beyond reason

At long last, the issue of "non smokers rights" has been opened for critical examination. (**The Journal**, Feb, July, Aug).

About 15 years ago, sociologist Howard Becker described a rather new species or mutation in modern societies: the moral entrepreneur. This breed of hustler begins with a crusade against some absolute evil: "He operates with an absolute ethic; what he sees is truly and totally evil with no qualification. Any means is justified to do away with it. The crusade is fervent and righteous, often self-righteous." Of course, he or she wants to force this new moral rule for the good of the sinner.

So, if successful, new rules are established (eg new public smoking laws.) However, the peril of success is that the organization becomes superfluous and the moral entrepreneur may be out of work. Both to preserve that righteous sense of crusade and to preserve one's employment and *raison d'etre* in that job, the cause must be broadened or extended. Of course, professional consultants who share the crusade must be recruited. The crusade becomes institutionalized, a permanent source of sophisticated nagging — and governments, like individuals, tend to give in to those nagging "squeaky wheels." Note the squeakiest of these wheels, our moral entrepreneur, has built a satisfying, successful, and ego-gratifying career for himself.

'We live in a pluralistic society. Freedom should not be compromised by the self-righteous.'

Let us consider the contemporary Non-Smokers Rights Association. Note that it began in response to a genuine need — smoking had spread indiscriminately to any and all situations, constituting an annoyance and, at times, a health hazard. Smokers had to rediscover a sensitivity and a courtesy which had declined in recent years. A new balance had to be sought, and we're struggling toward one.

However, the crusade seems not aimed at reasonable balance, but at an extended crusade against smoking itself. Note the position on the "absolute evil" of second-hand smoke. A basic parameter of any pharmacological issue is dose-level; at sufficiently high concentration, no substance is safe. However, the crusade seems not to be concerned with the concentration of smoke, the air circulation, and space enclosure involved. Second-hand smoke is apparently the evil, regardless of whether it's in an elevator, airplane, bus or the huge Eaton Centre.

And there are games with majority and minority. The non smoker is presented as the majority, an issue totally irrelevant to one of *rights* in a democracy. Television urges the non smoker to "tell the smoker that you do mind," even if you don't. Meanwhile the emptiness in the non smoking sections of restaurants tell us that, perhaps, many of this minority really don't mind. Of course, our moral entrepreneurs seek to convince them that they do mind, after all.

The crusade continues. The smoker is stereo-typed as an uniquely weak and driven addict, insensitive to others, and deserving of the status of a pariah. Advertising cigarettes in the public transit system is, somehow, an infringement upon the rights of the non smoker. Selling cigarettes in a hospital shop is, somehow, another infringement upon these rights. So is the old custom of the gift of a cigar from a new father; our local chapter of "yentas" is campaigning to substitute ballpoint pens. From all sides, our poor non smoker is affronted by the very existence of this evil weed. Forget about unemployment, energy, refugees, and environment — one cause is enough and that cause is demon tobacco.

Given, that in sufficient concentrations, "second-hand smoke" is a potential hazard from which we need protection. Given, that some suffer from allergies to tobacco and deserve reasonable consideration (I wish, at times, that I could summon up the same self-pity and social concern with my allergy to ragweed — the "majority allergy.") Given, that a sense of courtesy with regard to smoking was lost, and must be re-discovered.

Given, too, that cigarette smoking is a health hazard which should, within reasonable bounds, be actively discouraged. Human beings are only human, and we all have weaknesses and vices which are not good for us. Smoking, drinking, over-eating, under-exercising, working in stressful jobs, consumer debt, excessive energy consumption, gambling, marital instability — the reader will forgive me if I have not included his or her favorite vice, all of which can cause problems to one's physical or emotional health. Perhaps even the "moral entrepreneurs" do something which isn't good for them. Perhaps someone will mount a crusade to correct them and they'll be grateful.

However, the reality for now is the anti-smoking crusade has become a highly visible and successful enterprise, which has out-grown its original purpose of non smokers' rights. By all means, let's examine the research closely, and develop social policy which is consistent with genuine evidence. But let us also recognize that we live in a pluralistic society, where the freedom to do things that aren't good for you can not, and should not be compromised by the self-righteous. In the name of civility to all of us who have any kind of human weakness (and cigarettes is not mine), I'd invite all moral entrepreneurs to "mind your own damn business!".

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The Journal welcomes Letters to the Editor. Letters, bearing the full name and address of sender, may be sent to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Editor... Letters to the Editor... Letters to the Editor...

Bartenders are in excellent position to help

The exchanges between the Addiction Research Foundation (ARF) and the Brewers Association of Canada and the Brewers of Ontario (the Brewers) made for interesting reading (**The Journal**, April, May). While I think I have to support the ARF recommendations contained in *A Strategy for the Prevention of Alcohol Problems* (**The Journal**, June 1978) I find some comments unavoidable.

I am not so certain that "clearly, the crucial issue (presumably, as to the prevention of alcohol problems) becomes the development of a strategy to prevent the expected increases in alcohol sales." It sounds as if the ARF is proposing a prevention strategy which has as a major goal to prevent any increase in the future sales of beverage alcohol. I believe such a goal to be unattainable and unrealistic. And, having some familiarity with the ARF, I do not believe that this is what the ARF is actually proposing.

Still, the way the sentence is worded (as it appears in the *Strategy*), a reader could form the idea that the ARF is urging a halt to alcoholic beverage sales. Possibly, the Brewers take this view insofar as the *Strategy* is concerned. If so, their reaction is not very surprising.

On the other hand, I think the Brewers over-reacted to the remarks of the ARF — taking (I hope) an unwarranted overall attitude of defensiveness, displayed by a largely ineffective attempt to discredit certain aspects of the *Strategy*.

Although such comments may seem petty, the apparent polarized atmosphere existing between the ARF and the Brewers is disturbing. Perhaps the ARF would have done better had it recommended a so-called prevention strategy which would have included the Brewers as positive and active participants in efforts and programs to reduce, alleviate, and prevent instances and incidences of alcohol misuse, alcohol abuse, alcohol problems, and alcoholism.

For quite some time, I have firmly believed that if there is ever to be any substantial reduction in the problematic uses of alcohol (including alcoholism), there must be formed a cooperative union between those who provide alcoholic beverages to society and those who are professionally concerned with alcohol problems. So far, both groups seem to regard each other as if one would almost welcome the demise of the other. In short, and in the main, the alcohol/alcoholism field and the alcoholic beverage industry seem to be polarized. That such a situation persists is certainly a disservice to the whole of society, particularly alcohol users.

In such limited space, I'll not begin to enumerate the many and varied ways by which the alcoholic beverage industry could be of invaluable aid and assistance to members of the alcohol/alcoholism field in attempts to reduce and prevent alcohol problems throughout society. However, I must point out that, as a group, bartenders and other liquor servers come into more frequent and more meaningful close and personal contact with more alcohol-troubled people than any other group, including members of the alcohol/alcoholism field. Moreover, bartenders and other liquor servers are often in an excellent position of influence as to drinking practices and patterns. Yet their potential is almost never utilized. The field would be wise to ask why such a resource has been heretofore largely ignored.

The idea of trying to get the alcoholic beverage industry actively and positively involved in efforts and programs aimed at alleviating, reducing and preventing alcohol misuse, alcohol abuse, alcohol problems, and alcoholism is not new.

In the United States, the idea of incorporating bartenders and other liquor servers into efforts and programs aimed at reducing and preventing alcohol problems (including alcoholism) has had very little success. It seems that, in general, members of the alcohol/alcoholism field don't take such a notion very seriously. There is almost constant concern over the lack of knowledge about

alcohol abuse, alcohol problems, and alcoholism among members of law enforcement, the medical profession, the judiciary, and so on. Apparently, there is very little concern that the very people who sell, serve, deliver, and dispense beverage alcohol to the public know almost nothing about the nature and effects of alcohol and alcohol consumption.

Maybe some day members of the alcohol/alcoholism field and members of the alcoholic beverage industry (both in the United States and in Canada) can stop having "exchanges." Maybe some day they can sit together in meaningful dialogue to discuss what both can do to help society.

James S. Cowan
Glen Ridge, New Jersey

(Editor's note: In his letter Mr Cowan indicated his occupation is that of a full-time bartender.)

More on treatment

I find The Journal interesting and informative, particularly those items dealing with Canadian and American developments.

I would like, however, to see more commentary on different treatment modalities. I would also like to see you encourage more agencies and institutions to advertise for counsellors and therapists through the classified section of The Journal.

Keep up the good work — and thanks for an all-Canadian publication.

Tom Chan
Moose Jaw
Saskatchewan

Smoking aired

I have been impressed by the fact that for the last year or two The Journal is much more open about the hazards of tobacco smoking. It has seemed that for so many years even among medical, scientific circles, the habit of tobacco smoking was like one's religion,or one's politics, or one's love life, that it was personal, and that it was no one else's business.

G. S. Bickle, MD
Homewood Sanitarium
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Guest Article

Hong Kong's registry yielding valuable data

By Miss Pow-ming Wu, George Kwong, and Gabriel Chiu*

The Hong Kong Central Registry of Drug Addicts (CRDA), set up in 1972, was aimed primarily at obtaining information on the total number of addicts in Hong Kong and comparing the effectiveness of various treatment modalities available. Later found to have many inadequacies, it was reorganized with the assistance of New York consultants, Dr Robert Newman and Bent Werbell.

Reorganization involved modification of objectives and introduction of a new computerized data processing system. Instead of counting the number of heads, which the old registry attempted to do, the new registry places more emphasis on the analysis of incidence, prevalence, and other addiction trends. It also serves as a tool to study and to contrast characteristics of the reported individuals from various agencies and it provides an objective means, through analysis of preceding and subsequent reporting history, to evaluate the effectiveness of various programs, especially those of treatment and rehabilitation.

Miss Wu is chief statistician at CRDA. Messrs Kwong and Chiu are her colleagues.

An important feature of a successful registry is its ability to eliminate duplicate counts of the same individual. To achieve this, a sophisticated computer matching system was developed. The Integrated Database Management System software package, used to accomplish the linkage of records, is the first of its kind ever set up by the Hong Kong government.

Another important feaure of the registry is its great flexibility. Through the use of a subsystem, data outside the scope of the existing system can be incorporated into the analysis. The registry is, therefore, in a position to analyze any group of individuals provided their identification information can be obtained. This capacity is particularly useful in studying the subsequent reporting history.

To ensure the findings of the CRDA are truly representative, serious attempts have been made to include as many reporting sources as possible. Up to now, there are more than 20 reporting agencies embracing about 170 reporting sources, made up of various government departments, voluntary agencies, and private hospitals. Government hospitals and private practitioners are conspiciously outside the system. Continuing efforts are being made to include new reporting sources. Up to the end of April 1979, some two-and-a-half years after the initiation of the project, the registry has collected a total of about 84,000 reports on 31,000 individuals.

So far, some of the major findings are:

- Heroin is the main drug of abuse in Hong Kong. Results indicate that 84% of the known addicts use heroin, 11% opium, and the remaining 5% abuse other drugs. Opium is mainly abused by older addicts. Very few people are reported as using non narcotic drugs as their primary drug of abuse.
- The majority of heroin addicts in Hong Kong use the fume inhalation method of administration but injection is rapidly gaining popularity and a considerable increase in the proportion of addicts using this method occurs when the heroin price is high.
- Sixty-four per cent of addicts known to the registry are aged 30 and above. About 32% of all reported individuals are between 20 and 29 years of age. Only 4% are under 20. However, among women addicts (who represent 5% of all reported individuals), there is a higher proportion of younger addicts than among men.
- More addicts report to treatment in the summer months.
- For subsequent reporting history, the likelihood of being reported again within the first three months from a previous contact with a reporting source, is found to be 31%. The likelihood of being reported again within the first year period is 60% and, within the second year, 73%. Moreover, there is evidence that the likelihood of being reported again is higher in the younger age group (below 35 years of age).

At present, reports received by the CRDA are handled in strict confidence. Active consideration is being given to the enactment of legislation to provide statutory guarantees and safeguards regarding confidentiality of records kept in the CRDA as well as in other sources and agencies. Such protection is considered essential to ensure the continued confidence of the reporting sources and agencies and of the addicts themselves, in the integrity of the registry.

In short, the system is seen as a benchmark in the fight against drugs in Hong Kong. The flow from it of regular trend reports is providing a more accurate and balanced picture of Hong Kong's overall drug problem to policy-makers in the government and the treatment agencies, than they have ever had in the past. It will be particularly valuable in shedding new and authoritative light on the adequacy or otherwise of our preventive education as well as our treatment and rehabilitation programs. It is our hope to share with all who are interested, details of our research, the methods we use, the findings we obtain, and the action which stems from them.

INTERNATIONAL

Methadone patients misinformed about drug

By Lachlan MacQuarrie

HONG KONG — More than 25% of Hong Kong's drug addicts still believe methadone will change skin color. And more than 40% believe it will cause impotence or sterility.

This is even after they have taken methadone themselves through community drug treatment programs.

These were among the findings outlined by Lin Yuk Choy of the Hong Kong Discharged Prisoners Aid Society (DPAS) in recent research: Drug Addicted Ex-Prisoners' Attitudes to Methadone Treatment Programs.

Because of the close relationships between drug addiction and crime in Hong Kong, a significant proportion of the ex-prisoners served by DPAS are addicts who have relapsed following their release from prison. Many of these at some stage of their addiction, have turned to, or have been referred to, either the Methadone Maintenance Program or the Methadone Out-Patient Detoxification Program which are operated by the Hong Kong Government Medical and Health Department.

Mr Lin had been impressed by the extent to which DPAS clients seemed to be misinformed about methadone and designed a study to examine this.

According to Mr Lin, ignorance about methadone is capitalized upon by traffickers. "They will try their best to persuade the patients to stay away from methadone and go back to heroin. So far, they have adopted two forms of operation, namely to spread false rumors against methadone, and to supply free drugs to patients under special conditions."

Mr Lin interviewed 100 clients being assisted by DPAS, all of whom were both ex-prisoners and drug addicts. This represented 2.4% of all DPAS cases for 1977, the year he conducted his interviews. Fifty of these clients had received service from one of Hong Kong's methadone programs, while the other 50 had not. Age distribution of the two groups was similar with ages ranging from 20 to 70 years. The average age of the methadone "graduate" was 42.3 and ages of those who had not used methadone averaged 43.1.

Of the 50 addicts who had not attended a methadone program, about half said they had not done so because of fear that methadone would be harmful to health. Six per cent had preferred other modalities such as residential treatment.

Curiously perhaps, members of the group who had attended methadone maintenance or detoxification programs were more convinced than members of the non methadone group about the negative effects of the synthetic narcotic. Forty-two per cent of methadone takers believed the drug could cause one to become impotent or sterile. Thirty-four per cent of the second group believed this.

Similarly, regarding skin pigmentation, 28% of the group having experienced methadone believed the drug could change skin color to black or yellow, while 16% of the non methadone group accepted this statement.

Another rumor which Mr Lin said has been propagated by traffickers is that, "methadone will lead to addiction which is more difficult to cure than heroin addiction." Of the 100 DPAS patients interviewed by Mr Lin, 34% firmly believed this statement, 25% definitely did not believe it, and 41% did not know.

The study suggests that beliefs of this kind may have seriously affected the success of Hong Kong methadone programs. Of the group of 50 who had attended these programs, 36 or 72% "had doubts about methadone while they were taking it".

Mr Lin acknowledges in conclusion that his sample is small and that it is concentrated in a particular group of heroin addicts — those who are ex-prisoners. But he believes, nevertheless, that he has found evidence of "confused and inconsistent attitudes" which he recommends be tackled as part of a major health education and drug prevention program in Hong Kong in order to make existing methadone services more effective.

Overdose deaths also rising

West German addicts on increase

By John Dornberg

BONN — West Germany has recorded a sharp rise in hard drug addicts and deaths due to overdose, according to the federal ministry for youth, family, and health affairs.

From November of last year, to May of this year, said Hans-Georg Wolters, the health ministry undersecretary, the number of regular users of heroin and other hard narcotics and addicts has risen from around 40,000 to between 44,000 and 46,000.

Narcotic-related deaths are up sharply, too. In 1976, said Mr Wolters, there were 344 in West Germany; in the following year authorities registered 390 and last year there were 400.

'Free heroin samples'

But during the first four months of 1979 alone, the figure was 181. If that trend continues, Mr Wolters said, the total for the year will be 540.

Mr Wolters and West German state officials responsible for drug control attribute the sharp increase to a change in dealing tactics and to an oversupply of heroin on the market that has led to record-low prices.

As a result of intensified police work, he said, dealers have shied away from traditional sales locations such as discotheques and youth centres, and have "decentralized" their operations. There have been cases of heroin being sold and offered at the house doors of young people.

Dealers are singling out youths known to be hashish users and frequenters of the "scene." They are offering them free trial doses of heroin.

'Dated drug laws'

The federal government, meanwhile, has reported on its efforts to assist the states in combatting drug sales and addiction with propaganda efforts and advice on rehabilitation programs.

(There is no federal police authority in West Germany, with the exception of the Wiesbaden-based *Bundeskriminalamt*, which serves as a coordinating agency. Law enforcement, as a result, is up to the interior ministries of the 10 states.)

Total expenditure, according to Mr Wolters, has topped DM40 million (about Cdn. $22.8 million) since 1970. An equal amount, he said, had been spent by the states.

Concurrently, Heinz Schwarz, the senior Christian Democratic (CDU) opposition member of the *Bundestag*'s internal affairs committee, recommended higher penalties for drug selling and trafficking and a more lenient approach to users, particularly first-time offenders, of hashish and marijuana.

The maximum period of imprisonment for trafficking, he said, should be raised from 10 to 15 years.

West Germany's drug control laws date from the early part of this century.

Tourist affect islands

ST THOMAS, Virgin Islands — The special alcohol problems of people in Caribbean countries were addressed at the College of the Virgin Islands here when more than 60 medical and social work professionals met for the fifth annual Caribbean Institute on Alcoholism.

Added to the high rate of alcoholism indigenous to the Caribbean islands are alcohol problems brought by tourists and retired persons who have settled there.

There is an increasing number of alcohol programs in the area, as a result of the annual Institute, according to Donald Meeks, a co-director of the Institute and the director of the School for Addiction Studies, Addiction Research Foundation Toronto.

As examples, he cited an in-patient alcoholism program attached to a hospital in Bermuda, an in-patient and out-patient program in St Thomas, and a new out-patient program in the island of St Lucia.

"The course provides basic knowledge of findings in alcoholism studies and problems in the Caribbean area, combined with a presentation of the skills required to deal with the problems," Dr Meeks said.

The two-week summer school is supported by the Pan American Health Organization, the Canadian International Development Agency, The Trinidad and Tobago National Council on Alcoholism, the Virgin Islands government, and private firms and agencies.

Director of the Institute is Michael Beaubrun, professor of psychiatry, University of the West Indies, and co-directors are Eldra Shulterbrandt, director of the Reichhold Art Centre, St Thomas, and Dr Meeks.

Donald Meeks

Drug boom in SE Asia?

WELLINGTON, NZ — Australia and New Zealand could become staging posts for traffickers bringing heroin into North America, according to a United States drug enforcement officer.

The director of the US West Coast Drug Enforcement Bureau, J. Jenson, was attending a training course for police from 14 Pacific countries.

He said the reduction of heroin production in Mexico could lead to a boom in trafficking from South-east Asia, with Australia, New Zealand, and other Pacific countries as logical transit points.

Tobacco industry target #1

WHO spearheads global attack on smoking

Tobacco growers around the world are to come under intense pressure to switch to alternative crops in the interest of health. Some countries in Africa have only recently introduced tobacco in the hope of lucrative exports. But United Nations economists argue that their profits are going up in smoke. This report from Thomas Land.

GENEVA — Several international organizations of the United Nations are preparing for a joint global campaign against smoking. It is to concern such essential issues as crop substitution and market forces. The drive is to be spearheaded by the World Health Organization (WHO).

"The process of mobilizing public opinion is already gathering speed," says WHO information attache Nedd Willard.

"This organization will take the leading role in helping countries to learn from each other and in cooperating with all efforts to rid themselves of this plague . . . Other members of the UN family, such as the Food and Agriculture Organization, the International Labour Organization, and the UN Children's Fund are being drawn into the struggle."

About 120 countries are engaged in growing tobacco; and any ban on cultivation would have important economic and social consequences. Some countries, particularly in Africa, have only recently introduced tobacco in the hope of lucrative export revenues. UN economists will now seek to persuade them to switch to alternative crops in the interest of their long-term economic prosperity as well as health.

For WHO, the world program against smoking is crucial because it ties in with its long-term commitment to the establishment of reasonable health care systems for all by the turn of the century. The campaign follows a top-level decision taken by WHO to press for a total, global ban on all forms of tobacco promotion in the interest of public health.

A medical expert committee of the organization, headed by Sir George Godber, the former chairman of Britain's Health Education Council, earlier issued a sharply worded report blaming the international tobacco industry for causing unnecessary deaths.

The WHO committee recommended that all tobacco exports should be discouraged and that upper limits should be established for permitted tar, nicotine, and carbon monoxide levels in tobacco products — and that these limits should be progressively lowered as time goes on.

The experts called on the rich countries to ban immediately all exports of tobacco brands stronger than those permitted for domestic consumption. And they urged the poor countries to discourage smoking and to block the development of the tobacco industry.

As Sir George put it: "We must call for real action from governments now. The time for half-measures is past."

Some action is already taking place. Norway placed a total ban on all forms of tobacco advertising four years before the WHO recommendations. Many influential organizations, such as the British Medical Association and the European Community's association of consumer bureaus, are pressing for similar measures elsewhere. In Sweden, every cigarette package carries one of 16 warning texts. In Austria, sales tax on cigarettes increases with the tar content of the product. One Black Sea resort in the Soviet Union has banned smoking not only in schools, hospitals, and offices — but even on the beach.

Many problems raised by WHO's joint campaign against smoking still need to be solved. "Techniques for helping addicts to stop smoking have a long way to go before they are cost-effective and generally applicable," the organizers admit.

"Pharmacological and physiological questions remain unclear; and more work is needed. There are problems of crop substitution, employment, conditions of work, and economics to be worked out."

Teachers will have an important part to play. Dr Halfdan Mahler, the WHO director-general, recently called for new measures at a world conference in Stockholm, seeking aggressive, compulsory motivation against smoking in all primary and secondary schools.

Zambia leading painful transition?

GENEVA — The Virginia Tobacco Association of Zambia has revealed the country's commercial tobacco growers are quitting the business "at an alarming rate" because "they see no future in the industry."

This may well be the beginning of a trend — long sought by development advisers — away from undue reliance on the tobacco trade for support of the fragile economies of Third World countries.

Indeed, Zambia has been something of a trend-setter in Africa. It poured many millions of *kwacha* worth of investment into the tobacco industry at the time of Rhodesia's illegal declaration of independence in 1965 in the hope of attracting export revenues previously earned by the tobacco industry of Britain's rebel colony just south of the border.

Many countries followed the Zambian example, sharing handsome profits from the partially successful international trade sanctions which were to bring the Rhodesian tobacco industry to the edge of ruin.

And their short term boom was further encouraged by a basic shift in the world industry, due largely to governmental measures in the rich countries intended to discourage cigarette smoking because of its harmful effects on health.

The biggest world tobacco producer is no longer the United States, as it was in 1975, but the People's Republic of China. And the Chinese, too, have just launched a gigantic national campaign against tobacco consumption.

Today, a staggering 69.7% of Zambia's total agricultural exports comprise tobacco. Yet the country's tobacco association says that only 35 commercial growers are left still in business, and that 600 tobacco fields worth many thousands of *kwacha* are left unused.

The reason: low world prices, high local taxes, and lack of special governmental incentives.

The decline of world prices is due to a drop in demand throughout the rich world. Britain, for example, which is one of the world's biggest tobacco importers, consumed 4.7 thousand million cigarettes fewer in 1977 than five years earlier. In addition, cigarette filters are getting gradually longer, reducing the tobacco content of each cigarette.

But there has been a corresponding increase in cigarette smoking throughout the developing countries. An expert committee of the World Health Organization recently warned in Geneva that the adverse effects of increased cigarette consumption could well undermine current achievements in the developing world in the fields of nutrition, sanitation, and the control of infectious diseases.

And it emphasized: "A door might be opened to serious difficulties if tobacco consumption were allowed to grow without control in the relatively new economic markets of the Third World where the powerful tobacco companies have free hand . . . In the long run, the economy of the developing countries will be negatively affected, besides the health of their populations, if they start relying on tobacco production as a source of revenue."

The flight of Zambia's commercial tobacco growers from the business may thus be only the first sign of a major adjustment in the developing regions. If so, the transition is likely to prove slow and painful.

For no country in the world, warns one influential development adviser, can afford to deprive itself suddenly of more than half of its agricultural export revenue.

Rich/poor must put health before money: UN

Thomas Land reports

GENEVA — Fresh evidence confirmed by medical scientists now links excessive drinking with certain forms of cancer and heart disease, according to an authoritative specialist report published here for the guidance of governments.

It is also associated with lowered resistance to infection and with tuberculosis, says the report, published by the United Nations World Health Organization (WHO), which is seeking drastic measures to combat alcoholism worldwide.

The study warns pregnant women that excessive drinking could lead to developmental retardation of their progeny. And it points out that, especially in the poorest countries where alcoholism is on the increase, the diversion of family income to satisfy a parent's heavy drinking habits often contributes to "secondary poverty," culminating in the malnutrition of children.

According to the UN experts, alcohol-related sociological problems are increasing rapidly in the rich and the poor countries. They urge governments and community leaders in countries on both sides of the poverty gap to adapt urgent and drastic measures both nationally and internationally. These countries are asked, essentially, to put health ahead of economic interests.

The regulation of alcohol production, the control of imports, and the limiting of sales outlets are among legislative measures that have proven effective (where properly applied), the report says.

But its authors advise stronger measures to confront the escalating problem. They advocate further controls, such as provision for compulsory attendance by drunkards at rehabilitation centres as a condition of continued employment, the detention of drunken drivers, and more random road-block tests to determine the alcohol content in the blood of drivers.

"An essential aspect of any country's response," they observe, "is the political determination to promote and to adhere to policies that are bound to be controversial and that will need to contend with powerful interest groups. Some of the policies to be recommended will inevitably have (adverse) implications for the alcohol industry . . ."

Turning to the specific problems of the developing countries, the report says "the evidence of increasing damage in a large number of such countries suggests that alcohol-related problems constitute an important obstacle to their socio-economic development and, in addition, are likely to overwhelm their health resources unless appropriate measures are taken."

But the magnitude of the problem is evident in most countries, whatever their state of industrial development. The report offers devastating evidence illustrating how the health services globally are experiencing an increasing burden from alcohol-related health problems.

And the study warns: "The diversion of scant health care resources to deal with alcohol-related problems — such as traffic accidents or injuries from drunken brawls burdening casualty departments and operating theatres, cirrhosis patients occupying beds, and delirium tremens demanding emergency care — may put a serious strain on medical services that are already over burdened."

Alcohol victimizes children indirectly

By Edith Robb

FREDERICTON, NB — Children may be innocent victims of alcohol in at least four ways, according to Arlee McGee, a registered nurse and chairman of the woman's program committee of the New Brunswick Alcoholism and Drug Dependency Commission.

She told a recent meeting here she was basing her observations on personal observation of 20 years of nursing and talking to young people who come to her for guidance.

The first abuse to children growing up in a home where alcohol abuse is predominant, is they are taught to live in an atmosphere of "half-truths and white lies."

"They learn that parents do not always mean what they say. They may experience verbal and physical abuse; they learn to place no reliance on words, but only on actions. They do not learn the meaning of shared responsibilities. They have few, if any, rights. In fact, they are caught in a constant shift of varying moods and inconsistencies."

The second abuse is that there are often double standards, and children are given conflicting guidelines.

"They have parents who abuse alcohol and have weekend drunks, frequently use tranquillizers or other mood-altering substances, have routine cocktail parties, or there may be chronic alcohol use by one or both parents. But these parents preach that the children must abstain or act moderately when it comes to drinking. In other words, 'do as they say, not as they do.'"

The third family situation where children become victims, according to Ms McGee, is the one in which there is "moralistic preaching of the evils of alcohol" and the atmosphere is so rigid it restricts the child from learning his or her own controls or responsibilities.

"This foundation fosters rebellious or guilt-ridden adults," she added.

Finally, she said, homes where there is ignorance of facts about drugs and alcohol create an abnormal environment for the child who has to interact in today's society.

"Most children recognize the ignorance of parents who do not know the facts on, for example, alcohol or marijuana. Alcohol is our third largest killer. Yet some parents say: 'I'm glad my child only drinks beer and doesn't smoke dope.'"

Alcohol/drug OD coma shorter

By Dorothy Trainor

MONTREAL — Results of a Montreal study contrast with a general belief about mixing drugs and alcohol — that the drug overdose case will be in worse shape if he or she has been drinking as well.

The Montreal General Hospital study looked at drug overdose patients admitted in coma to the intensive care unit and compared the outcomes in patients where ethanol was detected, and in those where ethanol was not detected.

"The evidence did not support the idea that those patients who took ethanol concomitantly with their overdose have a worse outcome. The only difference in outcome was in the *shorter* duration of coma among those patients who had taken ethanol as well," said Charles Dumont. Dr Dumont, division of clinical pharmacology, was speaking to the annual meeting here of the Royal College of Physicians and Surgeons of Canada.

The median duration of coma was 12 hours for overdose cases where ethanol was absent, and seven hours for those where ethanol was present.

This study is part of a larger drug study still going on at the Montreal General Hospital, so results should be viewed with caution, it was stated. The purpose of the study was to evaluate in the clinical situation if the ingestion of concomitant ethanol does or does not worsen overdose cases.

The two-year investigation reported involved 203 overdose patients admitted during that period to their intensive care unit. Of these, 96 were in coma and formed the study group.

"Ethanol was detected in 31 of these patients. Ethanol was not detected in 65. We defined coma as being unresponsive to pain or to verbal command and we excluded those patients who had taken narcotics," Dr Dumont said.

"We also compared our ethanol-present and ethanol-absent groups as far as the drugs ingested were concerned. They had taken benzodiazepines, barbiturates, tricyclic antidepressants, phenothiazine, etc, and we could find no difference except in the benzodiazepine patients. The proportion of these patients where ethanol was absent was significantly greater," he said.

However, there was a significant difference among those who had taken mixed drugs with the frequency being considerably higher in the drugs-only subjects.

"From previous experience, we know that the use of mixed drugs prolongs the duration of coma. This difference may be one explanation for the shorter duration of coma in patients where ethanol was present."

Co-investigators were Dr Robert E. Rangno and Jo Han, RN

NB alcoholism bill soaring— education to be top priority

FREDERICTON — In five years the cost of alcoholism in New Brunswick has risen by more than 450%, according to the chairman of the province's Alcohol and Drug Dependency Commission (ADDC).

Everett L. Chalmers, who took over the chairmanship of the permanent body nearly a year ago when the ADDC replaced the former interim commission, told junior high school principals attending an awareness seminar on drugs here recently that between 1972 and 1977 the estimated cost of alcoholism to the province had climbed to $60 million from $13 million.

This figure included costs to industry and business, losses in sales and productivity, accidents and property damage, hospital costs, and the costs of the involvement of the departments of justice and social services.

Dr Chalmers said the commission's first priority is a new educational approach to alcohol and other drugs. He said Canada's major diseases are due to lifestyle and are self-inflicted. He said that while the decision to use the drug, alcohol, is properly a private and personal choice, should an individual make the choice to drink, "that individual assumes a responsibility not to destroy himself or others. That, in the broadest sense, is responsible drinking."

Grassroots from STASH

MADISON, WI — An update on Drugs of Abuse and Grassroots, two of their most popular publications, has been done by STASH, the non-profit drug information service.

The organization is also planning several new publications, including a 32-page comic book intended for teenagers and their families. Further information can be obtained from STASH, 118 S Bedford St, Madison, WI 53703, USA.

The Journal

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Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Linda Chung, coordinator of the group at (416) 595-6150.

All In The Same Boat

Subject Heading: Women and Alcohol, women and drugs
Details: 15 minutes, 16mm, color, sound.
Synopsis: A young woman is upset with her dull, trapped lifestyle as a housewife and mother. She feels that she is isolated from people and that her husband does not understand her problems. She was prescribed pills to help her sleep at night. In a neighborhood group with wives who are in a similar situation, they talk about their drug and alcohol use and the need to make changes in their lives.
General Evaluation: Good — very good (4.6). A highly contemporary, interesting, informative, realistic and well produced film with a strong emotional impact, this film was deemed an effective teaching aid.
Recommended Use: Likely to benefit audiences of 15 years of age and older. Particularly useful in pre-marital, prenatal, family life counselling, marriage counselling, and consciousness raising groups.

Let's Talk About Pills

Subject Heading: Trigger films. Drugs and youth, drug etiology and epidemiology.
Details: seven minutes, 16mm, color, sound.
Synopsis: Three possible occasions for pill taking are shown. The first situation is a young girl who cannot sleep. She goes to the medicine cabinet and sees some sleeping pills. Will she take them? In the second incident a boy on the playground is trying to persuade two other boys to take some pills. Will they accept? Finally, a mother is calling her son. He is upstairs in bed and an open bottle of pills is on the floor. What has happened? After each vignette the film suggests stopping to allow discussion about the incident.
General Evaluation: Good — Very Good (4.6). A contemporary, realistic, and interesting film with a clear message, this film was deemed an effective teaching aid. The A/V group liked what the film said about drug abuse and felt it could help in decision-making regarding drug use.
Recommended Use: With the presence of a resource person, the film is likely to benefit general audiences of eight years of age and older.

Senior Adults, Traffic Safety And Alcohol

Subject Heading: Impaired driving, alcohol and alcoholism overview.
Details: 11 minutes, 16mm, color, sound.
Synopsis: Alcohol is found to be involved in at least one-half of all traffic fatalities. A disproportionately high number of senior adults (over 55 years of age) have been killed in traffic accidents. In this animated film, an explanation is made of the effects of alcohol on the human body. The film cautions people to be careful when they drink, and offers strategies to control the effects of alcohol. Finally, the film urges the viewers to take action and help others avoid tragic consequences.
General Evaluation: Very good (5.0). A highly contemporary, informative, realistic and interesting film with a clear message, this well produced film was rated a good teaching aid with a length appropriate for most teaching purposes. The A/V Group liked what the film said about alcohol and its use.
Recommended Use: Likely to benefit audiences of 15 years of age and older. Particularly useful with senior adults and impaired drivers.

Alcohol

Subject Heading: Alcohol and alcoholism overview
Details: 17 minutes, 16mm, color, sound.
Synopsis: The history of alcohol from its discovery to its present use in Britain is traced. A number of popular alcoholic drinks are shown with their alcoholic content indicated. An animated section illustrate the effects of alcohol on our body and our central nervous system. Problems that arise from alcohol abuse are discussed — hangovers, drinking-driving, aggression etc. The film concludes that drinking is an important part of society. Decisions related to alcohol use should be based on knowledge and understanding of the issues.
General Evaluation: Good (4.0). A contemporary, informative, realistic film with a clear message, this film was deemed an effective teaching aid. The A/V group liked what the film said about alcohol and its use and felt the film could help in decision-making regarding alcohol use.
Recommended Use: Likely to benefit general audiences of 12 years of age and older.

DEPARTMENT

New Books by RON HALL

Drug Addiction And The US Public Health Service

. . . edited by William R. Martin and Harris Isbell

This volume is intended to serve several purposes. It commemorates the 40th anniversary of the Addiction Research Center, reviews the accomplishments of the programs, and provides a historical account of the development of the federal drug abuse programs. Papers deal with historical accounts of aspects of research up to 1975, amphetamine research, clinical aspects of opiate antagonists, biochemical aspects, drug metabolism and detection, sleep studies, hospital treatment programs, measurement of subjective responses to psychoactive drugs, and other topics. This 40 year review will be of interest to workers and researchers in the drug abuse and related biomedical fields, and to historians of science.

(National Institute on Drug Abuse, 5600 Fishers Lane, Rockville, Maryland, 20857. 1978. 339p.)

WHO Expert Committee On Drug Dependence: 21st Report

This report, WHO Technical Report Series No 618, provides a complete survey of the whole field of evaluation of psychotropic drugs, beginning with the techniques used in animal studies and human pharmacology, and proceeding to methods of assessing the public health and social problems caused by the abuse of a drug. It then describes the assessment of therapeutic usefulness, which enables the investigator to determine the benefits that a psychotropic drug may confer in medical use. The report ends with a discussion of the problems that might arise if the list of substances in the 1971 Convention on Psychotropic Substances were extended to include salts, isomers, and precursors, and an addendum gives the scientific background to this complex question.

(World Health Organization, Canadian Public Health Association, 1335 Carling Avenue, Suite 306, Ottawa, Ontario, K1Z 8N8. 1978. 49p. $2.70.)

Reefer Madness: The History of Marijuana In America

. . . by Larry Sloman

Moving from its early use as a source of clothing and rope, through the medicinal applications of tincture of cannabis, and then on to the discovery that marijuana is a recreational drug, the author shows how radically conceptions of the substance have changed. In addition to the history, the author presents an account of the views and claims of the marijuana users themselves.

(The Bobbs-Merrill Company Inc, 300 West 62nd St, Indianapolis, In, 46206. 1979. 414p. $12.95.)

Other Books

Drugs and The Inheritance Of Behavior: A Survey Of Comparative Psychopharmacogenetics — Broadhurst, P. L. Plenum Press, New York, 1978. Survey organized on the basis of the utilization of techniques using standard laboratory animals. Sex differences: pharmacogenetical and other selections; strain differences — amphetamine and other stimulants, nicotine, anxiolytics, convulsants, and amnesics, alcohol, opiates, and barbiturates: cross breeding — diallel cross: recombinant inbred strains: overview. 206p. $30.45.

Characteristics And Functions Of Opiods — Van Ree, J. M. and Terenius L. (eds). Elsevier/North-Holland Biomedical Press, Amsterdam, 1978. Proceedings of the International Narcotic Research Conference, held in the Netherlands, July 23-27, 1978. Mechanism of opiod tolerance and dependence: neurotransmitter and functional roles of endorphoins: chemical and structural aspects of opiods: biosynthesis, release and metabolism of endorphins: neurochemical effects of opiods: behavioral aspects: receptors. 520p. References, index. $68.00.

The Sleeping Pill — Hartmann, Ernest. Yale University Press, New Haven, 1978. History of sleep medication: who uses how much of what: sleep: effects of pills on sleep: insomnia: the psychodynamics of the sleeping pill: benefits and risks: toward a safe and rational sleeping pill: L-tryptophan: conclusions. Appendices include laboratory studies of the effects of drugs on sleep, and a clinical study of sleeping medication. References, index. 313p. $14.06.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

4th Annual Symposium — Pharmacotherapy With Emotionally Disturbed Children — Sept 20-21, Toronto, Ontario. Information: Ms A. E. Parsons, Community Relations Officer, Thistletown Regional Centre for Children and Adolescents, 51 Panorama Court, Rexdale, Ont, M9V 4L8.

Input '79 — 3rd Biennial Canadian Conference On Occupational Alcoholism And Drug Abuse — Sept 23-26, Ottawa, Ontario. Information: Input '79 headquarters, Conference and Seminar Services, Humber College of Applied Arts and Technology, Box 1900, Rexdale, Ont, M9W 5L7.

Clinical Orientation To Alcohol And Drug Dependence Seminar — Sept 24-28, Nov 19-23, Toronto, Ontario. Information: The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ont, M4G 3Z1.

29th Annual Meeting Of The Canadian Psychiatric Association — Sept 26-28, Vancouver, BC. Information: Canadian Psychiatric Association, Suite 103, 225 Lisgar, Ottawa, Ontario, K2P 0C6.

Canada Safety Council's 11th Annual Safety Conference — Sept 30-Oct 3, Quebec City. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario, K1G 3V4.

17th Annual Scientific Assembly Of The College of Family Physicians Of Canada — Ontario Chapter — Oct 14-17, Toronto, Ontario. Information: The Executive Secretary, Ontario Chapter, College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ont, M2K 2R9.

Detox Training Program — Oct 15-19, Nov 12-19, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

Medicine in the 21st Century: A Forward Look From Queen's — Oct 20, Kingston, Ontario. Information: Stuart L. Vandewater, MD, Associate Dean and Secretary, Faculty of Medicine, Queen's University, Kingston, Ont, K7L 3N6.

OAPSW 15th Anniversary Annual Conference — Nov 15-17, Geneva Park, Orillia, Ontario. Information: Ontario Association of Professional Social Workers, 696 Yonge St, Suite 501, Toronto, Ont, M4Y 2A7.

United States

The California Conference On Alcoholism — Sept 11-15, San Diego, Calif. Information: California Conference on Alcoholism — IV, c/o CAARH, 2146 West Adams Blvd, Los Angeles, California, 90018.

4th International Conference Of Therapeutic Communities — Sept 16-21, New York City. Information: Charles Devlin, coordinator, Daytop Village, Inc, 54 West 40th St, New York, NY, 10018.

Symposium on Substance Abuse — Sept 20-21, Williamsburg, Virginia. Information: Terri Pope, Mental Health Programs, Old Dominion University, Norfolk, Virginia, 23508.

Association of Labor-Management Administrators And Consultants On Alcoholism (ALMACA) — Oct 2-6, Detroit, Michigan. Information: ALMACA, 1800 North Kent St, Suite 907, Arlington, Virginia, 22209.

23rd Annual Conference Of The American Association For Automotive Medicine — Oct 3-6, Louisville, Kentucky. Information: AAAM, PO Box 222, Morton Grove, Illinois, 60053.

Evaluation Of The Alcoholic: Implications For Research, Theory And Treatment — Oct 12-13, Hartford, Connecticut. Information: Mrs M. Meadows, Alcohol Research Center, Dept of Psychiatry, University of Connecticut Health Center, Farmington, Ct, 06032.

Advancement in Alcoholism Symposium — Oct 14-15, Newport Beach, California. Information: Mr J. Fahey, Director, Advanced Health Systems, Inc, 881 Dover Dr, Suite 20, Newport Beach, Ca, 92663.

The 2nd Annual Prevention Conference — Oct 22-24, Morristown, New Jersey. Information: Ms L.E. White, New Jersey Prevention Inc, PO Box 299, Pine Brook, NJ, 07058.

Workshop On Effective Family Therapy With Drug Abusers — Oct 24-26, Philadelphia, Pennsylvania. Information: M. Duncan Stanton, PhD, Director, Addicts & Families Program, Philadelphia Child Guidance Clinic, 34th & Civic Centre Blvd, Philadelphia, Pa, 19104.

Annual Meeting of The Society Of Forensic Toxicologists — Oct 31-Nov 2, Williamsburg, Virginia. Information: Robert V. Blanke, Medical College of Virginia, MCV Station, Box 696, Richmond, Va, 23298.

National Conference On The Problems And Preventions of PCP Abuse — Nov 3-4, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, Ca, 94117.

Training Institute On Addictions — Dec 9-14, Miami Beach, Florida. Information: Training Institute on Addictions, c/o Dan Barmettler, Institute for Intregal Development, PO Box 2172, Colorado Springs, Co, 80901.

Abroad

10th International Conference on Health Education — Sept 2-7, London, England. Information: The Conference Centre, 43 Charles St, Mayfair, London, W1X 7PB, England.

International Conference On Alcoholism And Drug Dependency — Sept 3-7, Tegucigalpa, Honduras. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

International Symposium On Addictions: Biochemical Mechanisms Of Dependence And Brain Damage — Sept 13-14, Oxford, England. Information: The Helping Hand Organization, c/o The Alcohol Education Centre, 99, Denmark Hill, London, SE5 8AZ, England.

9th International Institute On the Prevention And Treatment Of Drug Dependence — Sept 30 - Oct 5, Madrid, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

African Conference On Drug Abuse — A Multidisciplinary Approach — Nov 26-30, Lagos, Nigeria. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1st Pan-Pacific Conference On Alcoholism and Drug Dependence — Feb 26 - Mar 7, 1980, Canberra, Australia. Information: Pierre Stolz, AFADD, PO Box 477, Canberra City, ACT 2601, Australia.

"Fifteen hours of agony." That's Jon Newton's description of his Harbour Light visit.

He reports below.

WAGING THE HOLY WAR

Ten in the morning at the Salvation Army's Harbour Light Centre, an alcohol and drug addiction unit on Toronto's Queen Street West. Time for coffee and a smoke.

But the cigarette between Eric's fingers has burned down unnoticed until it's almost at the butt. His face, normally pale, is flushed with anger, the color heightened by his hair, still coppery red at 54. I

'I have a message for doctors . . .'

have just asked him what he thinks of family doctors.

"I have a message for them," he says, voice unnaturally constrained. "Their ignorance is to be pitied."

Three-and-a-half hours earlier I had stated my name at the grill in the centre's side door and Eric let me in — as a guest. Captain Baxter Canning, who runs Harbour Light with his wife, Juanita, and 33-year-old Salvation Army soldier, Dave Strohm, wasn't due in until nine. Meanwhile, the 18 men living at the centre were polishing floors, doing routine jobs, and generally getting ready for breakfast. It was the start of another painful day in their fight against alcohol.

With the Salvation Army behind them, the drunks and ex-drunks at Queen Street are engaged in an ongoing *jihad* — literally a holy war — against booze. It's as bitter, every bit as relentless, as any conflict being waged.

For me, it was the beginning of 15 hours of agony . . . the most unsettling, unnerving day I've spent since I stopped drinking three years ago. It was a "there but for the grace of God" situation, a powerful reminder I was only a bottle away from being inside Harbour Light, or somewhere exactly like it, as a client. The 15 hours will stay with me.

For Eric — ex-soldier, ex-merchant seaman, retired conman and liar — it was another day in the tiny basement office, checking fellow alcoholics in and out, keeping lists of whose turn it is to do the washing up, answering the phone, dishing out vitamins and medication, and settling in new arrivals.

He knows Skid Row like the back of his hand: he should — he's spent enough time there with the rummies and dead-beats. And between July and November last year, he drank his way through $5,000, ending up in November in a detox unit and, finally, at the Harbour Light for his third stay.

His outburst against family doctors was almost to be expected. Like many other drinkers, Eric's experience with the caring profession has at times been unfortunate. Nerving yourself to go into the surgery and coming out five minutes later with a bottle of pills and an admonition to "pull up your socks," doesn't exactly inspire confidence.

But then alcoholics are not the easiest people to deal with.

Two days earlier, I had sat with Captain Canning as he interviewed a 23-year-old St Catherine's man who claimed he'd kicked booze and heroin two months ago. Now he wanted help to stay off them.

"You play ball with me, and I'll play ball with you," he told Capt Canning.

"You'll do what you're told," was the Captain's answer. "Like everyone else who comes here, you'll spend three days inside the centre getting yourself together, and you'll spend another three weeks going to lectures and devotions.

"You can go out and look for a job, but you'll be back in at 11 pm, latest, and you'll let the staff know where you are at all times."

Tough. But necessary.

Tall and dark, the man was obviously high on something in spite of his claim to have kicked drink and drugs. He limped badly and his right arm and wrist were badly scarred, as was his neck. He later told me the injuries were caused when he jumped off a bridge during a suicide attempt. He also claimed to be a jet pilot, a Kung Fu expert, a restaurant owner, photographer, and journalist.

He stayed at Harbour Light two-and-a-half days, eventually leaving for Hamilton (Dave Strohm escorted him to the bus station and put him on board with a one-way ticket). His story about what he planned to do on arrival changed by the minute. And he left behind the almost palpable hostility usually left by young junkies spending time with older alcoholics.

"He'll be back, though" said Canning. "If not here, then somewhere else."

"Good riddance" was Eric's comment. "He's already upset everyone in the dormitory."

Most men ending up in a unit like the one on Queen Street have long ago hit rock bottom and are still there, their sex drive eroded by constant alcohol abuse. Women are out of reach — the reasons are obvious — and homosexual acts are often all that's left, says Capt Canning. Unless, like Eric, they can get on the wagon and stay there.

But sex, food, and everything else come a long way behind the never-ending search for the day's alcohol.

Every Harbour Light customer has to attend two classes a day on the evils of booze. Police officers drop in frequently, sometimes with documentaries emphasizing just how long the arm of the law is. Films detailing the serious affects of prolonged alcohol abuse are shown frequently. But I was surprised to learn how ignorant most of the men are about how drink damages their systems.

Perhaps a couple of no-holds-barred sessions on the subject of alcohol with expert members of the medical profession wouldn't come amiss.

One risk practising and ex-drunks do seem to avoid is that of using street drugs as substitutes. The reason is simple. Nothing can replace the effect of a good slug of cheap wine, or rubbing alcohol, burning its way down. Grass, hash, and all the other soft drugs come nowhere near.

"I tried pot and after a while I got high," says one inmate. "But there was no comparison to drinking. In fact, when I turned up at work stoned, my boss sent me on my way and told me to come back when I was straight. He said he preferred me drunk. So did I."

Religion — the program throughout has a strong spiritual bias — is one substitute which *is* encouraged. Alcoholics Anonymous (AA) may not like the comparison, but there is a definite similarity between the Salvation Army and AA approaches to keeping recovering alcoholics on the straight and narrow. AA has its 12 Steps. The SA has its 10 Steps. But the messages are identical. "Keep away from booze or it will kill you. There is a better way to live. A life of sobriety and faith."

Every Tuesday and Thursday an evening service is held. Drunks are encouraged to come in off the streets and share devotions with the inhabitants and staff. Even here a similarity to AA meetings is noticeable. AAs "share" their experiences; SAs give "testimony." But the result is the same — warnings of what will happen to alcoholics who try and bend the rules.

After the hour-long service, guests line up at the kitchen hatch for soup and a loaf of bread to take away. For many, it will be the only nutritious meal of the day. Just how welcome it is, is clear from the silence, broken only by the clank of spoons against china as the soup is eaten, not a drop wasted.

'The clear stuff will kill you . . .'

As they finish their meal, the men leave by the side door. Eric and Fred are on guard, watching for customers who couldn't be bothered to attend the service, but are now trying to sneak in for soup.

Money, and how to get it, is a major preoccupation. One of the latest fears centres on a move to make welfare cheques payable monthly instead of every two weeks.

Eric and Fred explained: "The way things were, a guy got his cheque, paid his rent, and stayed drunk for three or four days on what was left. Now he'll blow it and he'll have to get by for another three weeks or so until he gets his cash.

"This isn't too bad in the summer. In fact a few people we know haven't been so sober in years. But in the winter it will mean a lot of deaths. What do the authorities care? They're just interested in saving money. They don't bother to worry about what it will mean to men like us."

For these "men like us," one thing is constant — the tipple. Cheap wine if you're in the money, or shaving lotion laced with pop to make it a little more palatable. Rubbing alcohol is also a popular standby. "But you have to have the certified stuff," one man told me. "If it doesn't cloud over when you add water, watch out. If you drink the clear stuff it'll put you on your back for a few days if you're unlucky, or kill you if your luck's in."

The biggest fear confronting each and every man in the centre, however, is The Outside. What will happen when they hit the streets again?

Sadly, for the majority it will be straight back to the nearest drink — back to the drinking friends. Back to certain early death.

The men at this centre, and others like it, are drunks. They are often dirty, unshaven, rheumy-eyed, and wear filthy rags. They know anyone can step on them and get away with it.

They have no dignity, no self-respect. No pride. Nothing, except the next drink.

They are also human beings.

Every Sunday friends and relatives join the drunks at devotions. Many local people see the Harbour Light as their church.

On the day I visited, a young woman walked in with two children in tow. They had come to visit one of the men. "Can we take . . . out for a little while?" asked the mother. "Sure," says Capt Canning.

There is a little hope. But not much.

THE BACK PAGE

Antabuse, Temposil death risk

TORONTO — Doctors using Antabuse or Temposil in alcohol aversion therapy may be unknowingly exposing patients to high risks, including death, warn experts at the Addiction Research Foundation of Ontario (ARF).

Any physician or therapist contemplating prescribing either drug should first run patients through a thorough and comprehensive screening program to ascertain cardiovascular, renal, and liver function.

And the drugs should *not* be used as the sole means of treatment.

These warnings come after in-depth investigations in the Human Responses Laboratory — believed to be the only one of its kind — into the Temposil-ethanol interaction. Other studies reconsidered clinical uses of both drugs in the treatment of alcoholics and/or problem drinkers.

By Jon Newton

The conclusions, reached after three years of work, should lead to a major re-examination not only of the roles of the two drugs in the treatment of alcoholic disorders, but also of their use in *any* on-going therapeutic situation.

Full report Page 6

Reunion proposed for 1980 in US field

By Harvey McConnell

WASHINGTON — Chances are now excellent that the rift in the United States drug abuse field will be closed with a joint conference of the ADPA (Alcohol and Drug Problems Association), NDC (National Drug Congress), and the NDAC (National Drug Abuse Conference) in 1980.

Concrete proposals were worked out by representatives of the three groups in a meeting here to take back to their respective constituencies for final approval.

They agreed to set up a nine-member committee to draw up a program for a 1980 conference and to work out a proposal for a corporate conference structure starting in 1981. A 21-member group will then ratify the program and the proposed corporate conference structure.

At the same time, a joint grant application was to be drawn up last month to submit by an Oct 1 deadline to NIDA (the National Institute on Drug Abuse) requesting financial assistance for the 1980 conference.

Although Washington has been mentioned as the site of the 1980 conference, the final venue has not been determined.

Gary Jensen, ADPA President, told **The Journal**: "We don't want anybody to feel anyone is ramming anything down anyone's throat. The final site has to be processed through the various constituencies."

Dr Edward Senay, one of the NDAC representatives, said: "We've got the structure now to

(See — Joint — Page 6)

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The Journal

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Canadian study indicts gov't attitudes

Native alcoholism aid is meagre

By Manfred Jager

WINNIPEG — A Manitoba sociologist says he has found evidence Canadian provinces spend half as much money on the treatment of alcoholics who are natives than on white victims of the same disease.

Angus Reid, professor of social and preventive medicine, University of Manitoba medical school, said the discrepancy is the first definitive finding from an in-depth, national study of alcoholism and drug treatment facilities and agencies he started in 1976.

Dr Reid analyzed services, facilities, clientele, and budget structures of 367 services and institutions in Canada. Only 48 of them deal with native Canadians exclusively.

"With respect to natives, the key finding is that the level of funding is substantially lower on a per capita, a per client basis, than it is for whites — by a factor of about one-half. That's the one finding that I am going to be pushing," Dr Reid told **The Journal**.

He said the average level of funding in 1976 for 367 drug and alcoholism agencies with programs which catered primarily to whites stood at about $155,000. Programs catering to native Canadians had average annual budgets of only $77,000.

He said this is an indictment of the attitude of provincial governments to native people right across the country, but particularly in the western provinces — "especially when one takes into consideration the profits provincial governments make from the sale of liquor."

Full report Page 4

New methaqualone axis 'startling'

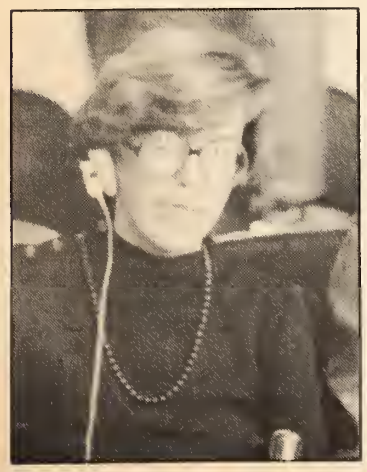
By Harvey McConnell

WASHINGTON — Millions of methaqualone tablets are being manufactured in Colombia from raw materials brought in from West Germany and then flown in secret to the United States.

This "really startling" development in the illicit drug market is so new "we have not developed yet a thorough international policy," according to Mathea Falco, state department advisor to the president on international narcotics matters.

Ms Falco told the Alcohol and Drug Problems Association and National Drug Congress conferences here that the raw materials are smuggled into the remote areas of Colombia, also headquarters for marijuana and cocaine traffic north.

"It is then packaged into tablets for picking up by Lear jets which fly down from Florida. In the last few months, literally millions of tablets have been brought in.



Mathea Falco

Liberalizing drug laws is 'active encouragement' to illicit production, Asian nations tell the West. See Page 10.

"It is really amazing to me that there is the market in the US which would pay for that kind of complex production system." It seems to indicate that "as other kinds of drugs become less available in the US, use patterns will change and other kinds of drugs and a means of supply will come leaping forward."

Ms Falco said what can work to the advantage of the US can have a rebound effect abroad: Western Europe "is encountering a flood of high quality heroin coming out of Southeast Asia, Afghanistan, and Pakistan, and it is relatively available at comparatively cheap prices."

While the US has a slightly improved figure for heroin addiction and heroin overdose deaths, "West Germany had as many heroin overdose deaths last year as the US but it is only a fourth the size."

The drop in the value of the dollar means it is more profitable for traffickers to smuggle heroin into Europe and sell it than to go through the additional hazards of getting it into the US.

Ms Falco: "The thing that is striking to me in the context of changing drugs and use patterns around the world is not only usage in the developed countries of Western Europe, with heroin not unlike what we had in this country in the late 1960s, but also in places like Burma, which is an extremely remote place almost completely cut off from modern trends, certainly any towards urbanization.

"Thailand is obviously a lot more exposed than Burma, as is Malaysia, another Southeast Asian country. All have had indigenous opium use for generations but are now experiencing, for the first time, really severe heroin addiction problems.

"The Thais estimate they have 200,000 heroin addicts — in the US we have about 450,000 addicts — and that's a lot of addicts for such a small country. This has become truly a global phenomenon."

Ms Falco said many countries have adopted tough laws and actions against drug use and abuse. Some actions, such as those of Singapore's Premier Lee Kuan Yew, may seem tough to outsiders.

However, in her travels, she hears a constant refrain from leaders in developing countries. "They are worried about young people becoming productive members of society. They talk very passionately about human beings as their only resource and they cannot allow drug abuse and drug use to creep through their society."

Inside

70 million teenagers

are the target of White House drug abuse fight led by Lee Dogoloff
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Sex therapy program

should be part of rehabilitation for alcoholics says Jan Dowsling
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Young Chinese women

in Hong Kong are moving to drug use contrary to traditional pattern
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NEWS

70 million teens the target

Drug abuse blitz launched

NEW ORLEANS — A vigorous campaign against drug abuse among its 70 million teenagers has been launched in the United States by the Carter administration.

Lee Dogoloff, of the White House Domestic Policy Staff, said a major aim is to provide accurate information about adolescent drug abuse to parents, teachers, and community leaders "so they will feel comfortable in their knowledge that adolescent drug use is damaging and that we have a right and responsibility to discourage drug taking behavior."

Another is to provide the momentum behind community efforts "which can offer our youth alternatives to drug abuse."

A film and fact book is being developed about the health and social consequences of marijuana use and what parents can do once they have this information. This will be distributed to schools, organizations, and libraries across the country by Jan 1, 1980.

The National Institute of Medicine of the National Academy of Sciences is preparing what is hoped will be an easily understood paper on the health consequences of marijuana use "so parents will feel more comfortable and secure as they take a firm position in discouraging marijuana use," Mr Dogoloff added in a speech to the National Drug Abuse Conference here.

State officials should receive by Nov 1, a compendium of material, books, and television and radio public service announcements aimed at the 12- to 14-year-old group and prepared by NIDA (the National Institute on Drug Abuse). The theme is "ways to say no now to drug abuse."

As part of the drive to get private sector support for the campaign, the National Football League has offered to include during the present season, television spots which focus on the family and the role it plays in promoting options to such behavior as drug abuse.

Mr Dogoloff emphasized that "government, with all its good intentions, can never duplicate community efforts nor inspire the same kind of commitment that is generated by people coming together on their home turf to solve a common problem."

Mr Dogoloff said statistics can give only an impersonal understanding of the problem. The 1978 figures of 14,000 emergency room visits and 260 deaths associated with PCP (phencyclidine) use, or the 10,000 emergency room visits related to marijuana use, do not take into account the mental anguish and torment of family and friends.

He added: "The use of illicit drugs uncontestably interferes with an adolescent's intellectual, social, and emotional development."

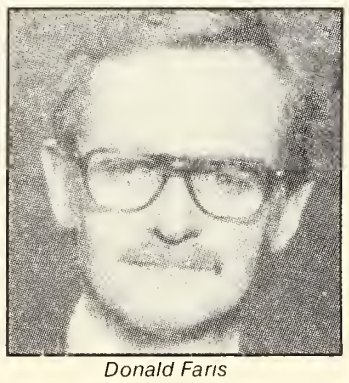
If the present adolescent drug abuse trends continue "we could soon acquire an unmanageable number of emotionally, intellectually, and socially handicapped young people. We could have a 'diminished generation' unable to function effectively, if at all, in an increasingly complex and demanding world."

'FAS parents should sue'

HAMILTON — Parents of children with fetal alcohol syndrome should sue federal and provincial governments, says the former education minister of Saskatchewan.

"These governments have failed to give adequate health warnings on products which are hazardous. If they will not help parents protect their unborn children, then they should bear the cost," Donald Faris told the annual Institute on Addiction Studies here.

Dr Faris, a United Church minister, was education minister from 1977 to 1978 in the NDP (New Democratic Party) government. He is now chairman of the board of directors of the St Louis Rehabilitation Centre in Regina, which treats alcoholics.



Donald Faris

He cited the April, 1979, *Pharm Chem Newsletter* estimates of FAS frequency in the United States: one to two per 1,000 live births, and a partial expression of the syndrome in three to five.

"If this is the case, then FAS (fetal alcohol syndrome) is by far the leading birth defect in our society, and the only one of the three leading causes which is preventable." (The others are Down's Syndrome at one in 600 births, and spina bifida at one in 1,000).

Drugs are hit with CFL kit

TORONTO — The Canadian Football League is tackling drug abuse with an information kit that has been issued to every player in the CFL.

The kit — *The CFL vs Drug Abuse, What Every Athlete Should Know* — contains information related to the non medical use of drugs. It has been assembled by the CFL with the cooperation of the Addiction Research Foundation of Ontario and Health and Welfare Canada.

CFL Commissioner Jake Gaudaur, in a memo to all CFL personnel said: "While there is no evidence to indicate that such abuse exists to any meaningful degree within the Canadian Football League, it would be naive to assume that there is none or that there never has been any.

"... It is my opinion that it is clearly evident that athletes have — everything to lose — nothing to gain — from indulging in the non medical use of drugs and/or through an involvement with them in any illegal way."

The 1979 information kit presents information on drugs and the law in Canada, descriptions of commonly abused drugs, and essays on drug use in sports. A similar kit was published in 1973.

Marijuana and caffeine are growing stronger

HAMILTON — The active ingredients in both coffee and marijuana are getting stronger.

The THC (tetrahydrocannabinol) content of the marijuana now available in Canada is up to 10 times higher than it was a decade ago, Donald Smyth of Alcohol and Drug Concerns (ADC) Inc told its annual Institute on Addiction Studies here.

And Richard Gilbert a scientist at the Addiction Research Foundation of Ontario, told the same group a cheaper strain of coffee from Angola and Indonesia, with a caffeine content twice as high as the Brazilian strain, is now being used more widely.

Mr Smyth, youth programs supervisor of ADC, said until 1970 most marijuana used in North America was of American origin, with a THC content of 0.2%.

It was supplanted by Mexican pot, with a THC content of 1% to 2%. After 1973, Jamaican and Columbian varieties became more popular, and their THC content is 3% to 4%.

"Just as youngsters are taking up heavy pot smoking at a younger age, the chemical content of the marijuana they are smoking is growing stronger and stronger."

The significantly weaker marijuana of a decade ago was also used in many of the early research projects, he said. "This is important in any explanation of why so many researchers during the 60s concluded that the drug was not seriously damaging."

Dr Gilbert, who has done extensive research on caffeine, said the bean of the arabica strain in Brazil is about 1% caffeine. But that is doubled in the robusta strain of Angola and Indonesia, which is "easier to grow, but tastes terrible."

"If you think coffee's getting bad, you're right. Brazil's importing robusta and mixing it with their stuff. It's a scandal, but the newspapers haven't got hold of it yet."

The robusta strain is being used particularly for drip coffees, which are gaining in popularity.

In an Ontario survey, he found wide variations in the caffeine content of "a cup of coffee," from 29 mg to 176 mg. The averages were 66 mg for instant, 74 mg for percolated, and 112 mg for drip. The overall average was 74 mg. Decaffeinated coffee averaged 2 mg. "The claim that it is 97% caffeine-free is basically true."

Tea analyzed in his survey showed an even greater variation: 8 mg to 91 mg a cup, with an average of 27 mg.

Jolly Rutabagans await 'decrimzer' festival

By Wayne Howell

Carnival in Rio? Octoberfest in Munich? San Fermin in Pamplona? Bah — the real traveller does not frequent these over-promoted, over-rated festivals. He seeks out authentic folk festivals in more remote corners of the globe. A good example of a genuine folk festival is the *decrimzer* festival held in Rutabaga, a tiny duchy located high in the Alps. Rutabaga is a picture-postcard principality best known for licit production of goats' milk cheese and illicit consumption of cannabis sativa.

It is a serious criminal offence to use marijuana in Rutabaga but before every session of the Rutabagan parliament, fun-loving Rutabagan politicians ritualistically announce they are through with studies, committees, and commissions — at long last they are going to decriminalize the weed. Co-incident with the ritual announcement, church bells toll throughout the alpine meadows and valleys so that every Rutabagan knows the *decrimzer* festival has begun.

By tradition, the festival is kicked off by the members of the Rutabagan NORML (National Organization for the Reform of Marijuana Laws) chapter who rent a hall for a pot party to which members of the press are invited. The NORML leaders announce that at last victory is at hand and then pass around symbolic joints. This impresses some of the press and scandalizes the rest and is the signal for *der pressenweek* to start.

During press week, every newspaper editor in the land rushes into print with his views on the decriminalization isue. All manner of editorial opinion — pro, con, informed, uninformed — is allowed during *der pressenweek*. The editors even commission outside "experts" to write various op-ed pieces for "background," ritualistically selecting those experts who reflect the editorial stance already taken.

At the end of *der pressenweek*, bands of jolly Rutabagans gather together all the newspapers published in the last seven days and create a huge bonfire in the civic square of the capital city. The bonfire, and the frenzied dancing around the burning newspapers (none of which have been read since the Rutabagans know all the editorial positions by heart) signal the start of phase two of the festival, *der waffelinweek*.

Waffle week allows the politicians to get in on the fun. The Rutabagans gather in the civic square to watch them perform, gleefully slapping their hands together when a politician qualifies his clear-cut statement of intent by throwing in *der hooker*. The hook varies — usually it has something to do with "legislative priorities" (ie the bill will be introduced after the bill to set softness standards for toilet tissue is passed and after the bill to abolish laundry lint has had first reading). But occasionally a politician will come up with a new or unusual hook. For instance, at last year's festival, the fun loving, gnome-like Minister of Health (known as "the tiny perfect minister") said decriminalization would only occur if he could get a full debate on marijuana in the legislative assembly. The Rutabagans had a good laugh over that one.

Waffelinweek ends with the ritualistic sacrificing of a goat in the civic square. But at the same moment as the goat is sacrificed (symbolizing the death of the decriminalization bill on the order paper) a flock of white doves carrying sprigs of suspicious looking flora is released into the air.

These symbols of hope fluttering skyward signal the massed Rutabagans in the square to officially close the two week festival with the traditional theme song of festival, "some day decrim will come/some day decrim will come . . . .", sung to the tune of "some day my prince will come."

It is a touching moment, especially if the tourist stations himself on the left side of the civic square where he can see the prisoners in the local jail standing behind their barred windows, humming along softly, with tears streaming down their faces.

Research reports vs popular press

Pot's medical value 'overblown'

By Harvey McConnell

NEW ORLEANS — Use of marijuana as an anti-emetic for patients receiving cancer chemotherapy is probably "close" to legal medical use, believes Robert Petersen, assistant director of research at NIDA (the United States National Institute on Drug Abuse.)

Medical use blurred

At the same time, Dr Petersen believes that while marijuana may have legitimate medical use, "one of the unfortunate aspects of the marijuana controversy, to a certain extent, is that the value of marijuana as a therapeutic drug, in my judgement at least, is also overblown."

Several hundred cancer patients have taken marijuana derivatives to help ease the vomiting associated with chemotherapy. However, "at the present time, we have a very promising drug in this respect, promising to the point where I will not be surprised if its use for this purpose is approved."

Dr Petersen, and several other participants at a session of the National Drug Abuse Conference here, said marijuana's possible medical use is blurred in the public mind: in almost every case it is used in conjunction with, and not as a substitute for, conventional therapy, and often its efficacy is as low as 30%.

Dr Petersen said the scientific and medical reports of research are in marked contrast to the popular press reports "which generally overstate the advantages and treatments." This leads most laymen to believe marijuana is being used as a substitute for conventional therapy.

He added: "Whether marijuana or any of its constituents is useful for therapeutic purposes is totally irrelevant to whether it is desirable as a recreational drug." It "depends on all sorts of other considerations."

Marijuana was used for centuries for a variety of conditions. Its use declined at the end of the 19th century for reasons which are still relevant today.

Dr Petersen explained: "Marijuana in any of its forms is a very non standardized product; delta 9 THC is a fairly unstable molecule and breaks down rather rapidly; and it is also water insoluble, thus giving unpredictable results in being absorbed across the gastrointestinal barrier."

He cautioned against simplistic arguments for removing marijuana as a scheduled drug because of any medical benefits. "Amphetamines have a limited therapeutic usefulness without a doubt, barbiturates do, various sedatives do, and morphine and opiates certainly have a well recognized importance in protracted pain.

"The very real question which should be a legitimate debate is: to what extent are the present regulations that govern investigations of new drugs so bureaucratic, so detailed, so demanding in proof beyond all shadow of all doubt that they deny the American public certain drugs that are widely available, say in Europe, and that are acknowledged to be therapeutically effective.

Politics of marijuana

"This is a very legitimate issue and a much larger issue, and importantly so, than the simple issue of marijuana as an anti-emetic, which is obviously a very emotionally compelling argument to which we could all respond. Who would want to deny a dying or suffering patient whatever help it is possible to give? Certainly not I."

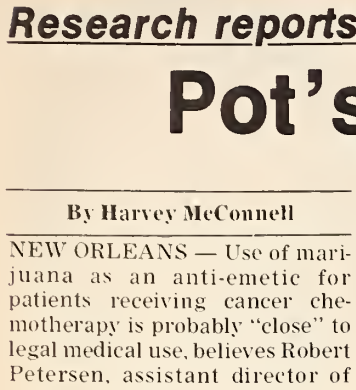
He said the current controversies over saccharin and laetrile, and the politics of marijuana, at times seem to threaten to overwhelm the federal agencies that were set up by Congress to act as regulatory bodies.

Celebrities' views on pot sway teens

By Betty Lou Lee

HAMILTON — Young people continue to get a message from public figures that marijuana is harmless, in spite of mounting scientific evidence to the contrary, says the supervisor of youth programs for Alcohol and Drug Concerns, Inc.

Donald Smyth asked 28 Grade 8 students in Toronto for their impressions of marijuana in June, and one of the answers he got was "Pierre Berton uses it, so it's got to be OK". Other answers were that it is less harmful than tobacco and alcohol, it is used to treat glaucoma, and it might give you bronchitis.



Teenagers say marijuana must be harmless because they hear that such public personalities as Pierre Berton (left) and Margaret Trudeau use it.

Six students in the class said they were daily users, and the majority were regular or infrequent users.

Mr Smyth, whose work keeps him in constant contact with school-aged children, cited other examples of marijuana's public image at the annual Institute on Addiction Studies here.

The Toronto Star published a recipe for hash brownies in August.

Margaret Trudeau's book tells of her smoking four marijuana cigarettes daily in her bedroom at the Prime Minister's residence.

A *Macleans* cover story on the illicit drug network credited small-time drug trading with "an aura of adventure and romance" which was now threatened by the big operators "on an international level."

"The reader was assured that the marijuana smokers are provided with 'high times and mellow evenings,' with few exposed 'to anything more dangerous than the friendly corner trafficker.'

"Is it surprising that the most recent survey of the Addiction Research Foundation found that marijuana has edged out tobacco as the second most popular drug among senior high school students in Ontario, or that 11% of American high school students are now estimated to be daily users?"

Mr Smyth said Dr Robert DuPont, former director of the United States National Institute on Drug Abuse (NIDA), has played a key role in liberalizing American attitudes towards pot. Yet in a TV documentary in Dec, 1978, he termed it a "dangerous drug."

"DuPont's shift in opinion is only one indicator that since the LeDain Commission reported in 1973, scientific opinion that marijuana is a harmless substance, or may be harmful, has been increasingly altered in favor of the opinion that it is harmful."

'Dialogue' falls victim to cutbacks

TORONTO — The federal government has dampened Dialogue on Drinking, the program aimed at warning the public about the dangers of alcohol and carried out in partnership with provincial and territorial alcoholism and drug commissions and foundations.

The program, which began in 1976, fell victim in the summer to government cutbacks. Its lifeline, public advertising, was cancelled mid-summer for the rest of the year.

A new proposal for an advertising budget will be submitted to Health and Welfare Minister David Crombie this month, according to Jack Nightsgales, manager of the program for the Health Promotion Directorate.

The proposal also will have to pass the scrutiny of the newly created Agency of Management, which is reviewing all advertising programs in government.

After the cutbacks, Dialogue was left with six weeks of radio advertising. It had planned 11 weeks and was prepared to buy 13 weeks of television advertising.

Also planned was the insertion into a prominent national magazine of a booklet of recipes of drinks for the holidays that included no alcohol.

The booklet, written by Margo Oliver, food editor of *Weekend Magazine*, will instead be distributed through the program's provincial partners. (In French, the booklet is titled *Les Illusionnistes.*)

Hamlet mixes liquor

TORONTO — Eighty-two of 93 people on the voters list in the far north community of Pelly Bay, Northwest Territories, showed up to vote in a liquor plebiscite this summer.

The question: Do you want liquor in the Hamlet of Pelly Bay? The answer: a fairly resounding "no."

Sixty-three people said no, 18 voted yes, and one ballot was spoiled, said *The Hub*, the Hay River, NWT, newspaper.

In US 32% abstain

ACAPULCO — The greater the number of abstainers in a country, the more ambitious its government is in preventing alcohol abuse, Gunnar Nelker of Sweden told the Third World Congress of the International Commission on Prevention of Alcoholism and Drug Dependency here.

For that reason, Dr Nelker rated the governments of the United States, Norway, Sweden, Finland, and France as "ambitious," while those of Japan, Belgium, Australia, Great Britain, Denmark, West Germany, and Holland were "non-ambitious."

He said the US led the countries named in non drinkers, with 32% of the adult population being abstainers, while the next highest was Norway at 23%. Denmark, West Germany, and Holland brought up the rear, with only 9%, 8%, and 4%, respectively, of the population being abstainers.

Dr Nelker, president of the ANSVAR group of insurance companies, which restricts its business to non drinkers, said the figures he cited came from a study of demographic characteristics of abstainers.

UK to act on Barbs

LONDON — There is a strong possibility Britain's Misuse of Drugs Act will soon be extended to include barbiturates.

The new regulations will mean that physicians prescribing the drugs will have to specify the name and address of the patient on a special register; the dose given; and the strength of the preparation.

Where the prescription is issued in instalments, there will have to be a direction as to the amount of each instalment and the interval to be observed between doses.

Moreover, prescriptions must be written in the physician's own handwriting (to prevent the issue of prescriptions by paramedical workers which have been signed by the doctor in advance).

These regulations are in response to continuing concern of field workers about barbiturates, although the number of prescriptions for the drugs has fallen from about 12 million in 1970 to about four million annually now.

In the early 1970s, an ambitious scheme for the voluntary control of barbiturates was backed by the British Medical Association. It was successful in persuading many doctors to prescribe safer sedatives, but it seems plenty of barbiturates remain to supply abusers.

NEWS

Native alcoholism -- token treatment?

By Manfred Jager

WINNIPEG — Canada's provinces seem to be operating on 'some sort of two class, racial' system in dealings with whites and natives, claims Angus Reid, professor of social and preventive medicine, University of Manitoba.

Per capita, natives receive about half as much money for treatment of alcohol and drug problems as whites do, Dr Reid found in a three-year, national study of alcohol and drug treatment facilities and agencies (see — Indians — page 1).

"The discrepancy in funding cannot be explained away by the size of the programs. I found that programs for natives, if they were smaller, the difference in bed numbers never amounted to more than three.

"If anything, one should argue that, given the kinds of problems that confront the native alcoholic, and given the problems that arise to all of society from the level of alcoholism among natives, we should be pouring proportionally more money into programs for the native population than we do for whites, on a per capita basis or a per alcoholic basis, or whatever.

"On an agency basis, the one clear message that came through to all of those who worked on this study was the complaint from the people who run alcoholism services for native people that they are not given the cash to do the job. That's a situation that doesn't seem to be changing and must be addressed very quickly, even if the native organizations themselves don't push as hard as perhaps they ought to."

If nothing else, the discrimination between whites and natives in the matter of alcoholism services flies in the face of the principle of equal access to health care for all Canadians, Dr Reid said.

"We seem to have some kind of a two-class system operating, on some sort of racial grounds, and it's just not right, that's all.

"I think that this, more than anything else, indicates some of the two-faced attitudes on the part of the people in our provincial governments when it comes to the problem of native alcoholism."

Research has shown that one-third of all deaths among natives are due to accidents and violence — a far higher percentage than among whites, Dr Reid said. "It is estimated that about 75% of all those deaths among natives are due to alcohol-related problems."

He found that during one recent year in Saskatchewan, 54% of all admissions to correctional institutions were natives, "despite the fact that only 13% of the total population is native. Seventy-five per cent of all breaches of the Saskatchewan Alcohol Act were committed by natives.

"In Alberta, 38% of all children in care are natives, and natives make up only 2% of the total population of that province.

"Fifty-seven per cent of temporary wards of children's aid societies, and 44% of permanent wards are natives. Again, there is wide agreement that alcoholism-related problems are at the root of much of this social breakdown."

A few years ago, Indians in Kenora, in western Ontario, captured international headlines when they occupied the town square to request certain rights for themselves. Kenora remains a town with problems and alcohol abuse is still central to those. Next month, The Journal publishes a full report — this time from the Indian point of view.

Canada is dealing with a major social problem in the alcoholism of its native people, Dr Reid said. "I don't even think it takes a great leap of faith to realize this. All one has to do is walk around the centre of most Canadian cities and you realize it.

"And then we find levels of funding for services for these people, which are not, by far, what they should be."

Why?

"The issue of political clout is obviously there, but I don't know whether I would put that much emphasis on the clout of the native people," Dr Reid said. "I think what happened is that some of the native organizations which started to push for the development of treatment programs for native people, were in a way bought off with small sums of money by government people who said 'we give you a treatment program' and then came across with, say, $50,000, thinking this would solve the whole thing."

Yet the development of these programs, in terms of expanded services and professionalization of staff, never had a hope of keeping pace with the increase in demand or with what has, in fact, happened for white alcoholism programs, he added.

"It's really very simple: If we don't provide appropriate service to the native alcoholic, we're looking at health and social problems on a scale that most whites would be very upset to have to live with in their community if they were properly aware of them. There's really no further doubt that alcoholism plays a very major role in the level of health and social problems we see out there."

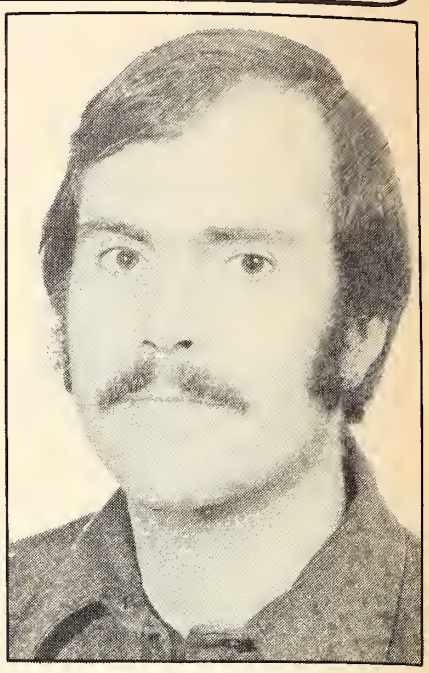
Dr Reid said most treatment programs for alcoholics in Canada are located in the prairie provinces and more than one-third of the people using them are natives.

About 8,000 natives are receiving treatment for alcoholism in Canada, Dr Reid said — 5,000 in the prairie provinces alone. Another 10,000 clients of alcoholism services in the prairies are white.

The total number of people in treatment for alcoholism in all provinces is estimated at about 80,000.

"Native alcoholism comes off as almost being a prairie phenomenon," Dr Reid said.

He said provincial governments three years ago made about $1 billion in straight profits from liquor sales, $2 billion was earned by provincial and federal governments together if such charges as excise taxes are counted in.



Angus Reid: "If we don't provide appropriate service to the native alcoholic, we're looking at health and social problems on a scale that most whites would be very upset to have to live with . . ."

In the prairie provinces alone, straight profit from liquor sales came to $209 million or $82 profit for each man, women, and child in the prairies.

"Profit made on the booze sold to each alcoholic in the prairies came to $1,511.65 that year," Dr Reid said. "Treatment expenditure per alcoholic was only $202."

Gov't shaman drowns

TORONTO — George Councillor, 42, the first Indian to be appointed as an official advisor and link between the native and white populations at the Lake of the Woods District Hospital, Kenora, Ont, died during a tragic boating accident late last month.

He was on his way to a wild rice plantation when the boat in which he was travelling with Ms Lorraine Jourdain, 32, was swamped. Both were thrown overboard but only Ms Jourdain made it to shore.

Police and volunteers dragged the area, but were unable to find Mr Councillor's body for five days.

He was well known as an Indian medicine man in the Kenora district and was appointed as an advisor to the hospital through a $26,400 grant made available by Ontario's Ministry of Health.

Md's Rx for morphine raises official hackles

VANCOUVER — A Vancouver physician who defied convention by prescribing morphine for a heroin addict, has had his wings clipped by outraged authority.

Robert G. Schulze's admission to a reporter that he had provided morphine to addict Denise Rutherford after she attempted suicide sparked:

- **A letter from the British Columbia College of Pharmacists instructing druggists to report to the College any past prescriptions for narcotics and narcotics preparations filed for Dr Schulze and details of any new requests.**
- **A boycott on filling narcotic prescriptions for him by most Vancouver area druggists.**
- **Police "harassment" of his patients, both addicts and non-addicts.**
- **An investigation by the BC College of Physicians and Surgeons.**

And as The Journal went to press, Dr Schulze reported the Bureau of Dangerous Drugs had just informed him that his right to prescribe injectable narcotics was being lifted.

Law enforcement authorities were uncertain whether Dr Schulze had committed a crime.

"It's not as if the drug is being prescribed to someone and then sold on the street," said an anonymous BDD investigator.

But the action defies a clear policy of the College of Physicians and Surgeons, which controls Dr Schulze's licence to practise.

"The use of morphine for drug addiction is not appropriate," said the college's deputy registrar Dr Craig Arnold.

Methadone, which is longer acting than morphine and is less euphoric, is the only drug approved for narcotic maintenance.

Dr Schulze said that since his announcement people identifying themselves as police officers have accosted patients outside his office and questioned them about the purpose of their visit.

Druggists have refused generally to fill his prescriptions for narcotics and he has resorted to frequenting drugstores in ethnic neighborhoods with foreign language pharmacists who might not have read their English mail.

"This is an attack on me and my integrity, and my patients are suffering," he said.

Despite the attack, he said, he has taken on several more addicted patients whom he is providing with morphine. The government has been notified in each case, he said.

But he thinks the writing is on the wall.

"Sooner or later they're going to nail me one way or another. The politicians are too scared people might find out there's nothing particularly dangerous or deadly about morphine and heroin."

UK to cut alcoholism support

LONDON — Despite repeated statements of concern about alcoholism expressed by successive British governments, the signs are that State cash support for rehabilitation and treatment will decline next year instead of increase.

For it now seems highly likely that a program to withdraw department of health and social security (DHSS) funding for British alcoholism agencies — by transferring responsibility to local authorities — will take effect in March, 1980.

The plan was hatched, apparently, during the cutbacks in DHSS spending introduced here by the former Labour administration. After the Conservatives ousted Labour at the General Election earlier this year, some workers hoped the trend would be reversed — at least for alcoholism.

But, it seems the hope was in vain. This is indicated by reports of a meeting between Secretary of State for Health and Social Security Patrick Jenkin and a pressure group from south London called Save Alcoholism Services (SAS).

A deputation from SAS saw Mr Jenkin and spelled out reasons for greater rather than less government support. (Notably the growing alcohol problems here and the effect they can be calculated to be having on the nation's productivity.) Mr Jenkin told the deputation, however, that although the government recognizes the growing problem of alcoholism, it would make no commitment to continued financial help at present.

A spokesman for SAS told **The Journal** hundreds of British alcoholics are being housed and, it is hoped, rehabilitated in hostels funded by the DHSS. If local authorities were expected to find cash to run such hostels the result would be that many problem drinkers would be thrown back to the streets.

Cross-addicted alcoholics the culprits

Detox units being clogged

By Betty Lou Lee

HAMILTON — Alcoholics cross-addicted to drugs such as barbiturates and benzodiazepines are forming a bottle-neck in in-patient units, says the executive-director of The Donwood Institute in Toronto.

They require hospitalization for six to 10 weeks in beds that could serve one alcoholic a week, D. W. Macdonald told the Institute on Addiction Studies here.

"They seem to be accumulating at a slow but steady increase, clogging up detoxication.

"The multiple-drug dependent person has been around for a few years, but only in the past couple of years have we encountered the very high intake Valium user, consuming up to 100 mg or 200 mg a day, to the patient's best memory, a function badly deranged by Valium.

"The brain disturbance from Valium is subtle and especially prolonged so some provision will have to be made for them to occupy less expensive facilities while they wait for return of brain adequacy."

The trend comes at a time when in-patient beds have been drastically reduced at most treatment centres, following the realization in the last decades that most alcoholics don't require them.

The Donwood, for example, started its day clinic in 1973 for selected patients. In the last five years, fewer than 25 patients have had to be transferred to the in-patient service for medical reasons. "Most treatment centres will, in future, not have any beds, but will have access to emergency beds in a local hospital for detoxication or emergency needs," Dr Macdonald said.

He questioned whether most alcoholics need, or can use, unstructured groups early in their therapy. The same brain dysfunction and alcohol dementia that cloud any psychological tests in the first few months of recovery often make the patients "less than desirable group members."

"In the short term unstructured group the common variety lasting only a week or two, only limited goals can be set. Insights of a dimension necessary to make lasting behavioral changes are rare . . . This kind of group will appeal most to the patient who is psychologically sensitive, articulate, assertive, and has life goals similar to those of the therapist."

D. W. McDonald

Behavior modification therapy, on the other hand, can be used early in recovery to good effect, he said, and has a good future outlook.

He also saw increased use of volunteers, partly because of budget pressures. The Donwood uses lay volunteers as clinical secretaries to keep a weekly, friendly contact with patients, and alumni of the Institute who act somewhat like AA (Alcoholics Anonymous) sponsors: "A guide and mentor, a supportive confidant."

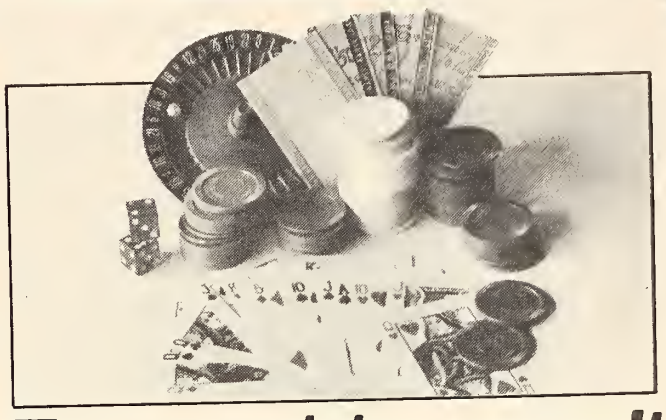
These two groups account for one-third the time spent by staff in patient care nurses account for another third. Physicians and group therapists account for 8% and 9% respectively.

Continuing to predict trends, Dr Macdonald said Antabuse is mandatory now at Donwood, but perhaps should be reserved for patients who can't stay dry without it — those with very poor impulse control and strong internal pressures to drink.

In view of recent reports of side effects of Antabuse (disulfiram), Dr Macdonald said: "We must consider the life-threatening nature of the syndrome we are trying to treat, as well as the fact that Antabuse is the only drug used in treatment that correlates with successful recovery, in considering whether to use it. Tranquillizers and vitamins do not seem to influence the final outcome of treatment."

Antabuse implants, however, have not produced the same alcohol-Antabuse reaction, and "a new drug with better absorption properties is needed."

In the debate about abstinence and controlled drinking, "no doubt there are many people for whom abstinence is an unacceptable goal, and these people we may lose . . by insisting on abstinence. But as of now, we have no way to predict who may become a controlled drinker, and no very effective procedure to help them become one."



Ex-gambler won't flip for a coffee

HAMILTON — He started his gambling career as a nine-year-old caddy at a Hamilton golf course, making nickel bets. He ended it when he was reduced to sleeping in the desert outside Las Vegas, conning winos out of their last buck by offering to get their bingo for them when they could no longer walk.

He wasn't even a successful gambler as a kid. By the time he was 12, he was paying $15 to borrow $10 from loan sharks, and cutting the tens in two so he could con his father into thinking he had $20 left from his earnings.

When he finally quit, one year and seven months ago, he periodically got the shakes. Not from withdrawal, but because "I had huge debts with hostile people who were a danger to my life. You get into situations you never dream of. When you can't get credit, you go to the shylocks."

Art, a member of Gamblers Anonymous, was telling his story at a session of the annual Institute on Addiction Studies here. It was a story that had one delegate, a member of Alcoholics Anonymous, exclaiming: "Thank God I was only hooked on booze."

Art wasn't a very successful gambler, but he was a successful businessman, which allowed him to feed his habit. But after 30 trips to Vegas in two years, he moved there. He blew his business, marriage, house, and car, as well as $35,000 he raised by mortgaging his parents' home. "I was in a daze to make money to get back to the table."

In one call to a Hamilton friend, trying to borrow money, he suggested the friend had about $20 worth of beer bottles in his cellar he could cash in.

He learned about Gamblers Anonymous in New Orleans, and attended Hamilton chapter meetings after taking a train home. The chapter became disorganized when its mainstay "fell off the wagon." He had refused to join some colleagues in buying a joint lottery ticket, and they won a million dollars.

Now a handful of Hamiltonians travel to Toronto meetings, and hope to re-establish their own chapter.

Art won't buy lottery tickets. He won't even flip for coffee. "There's such honesty in the group, I'd feel like I was letting my brothers down . . . People at the meetings understand, and you can make friendships again."

When he quit gambling, he said he felt "worthless. I couldn't look at anyone. I felt I had no right to be anywhere."

He feels lottery tickets are having an impact on addictive gambling. "They are hitting a lot of people who don't make much money. They're dreaming, and they are buying too many."

He estimates that half the members of Gamblers Anonymous are in debt to loan sharks, and although he feels "80% better," he is still looking over his shoulder.

Epileptics and pot paradox

TORONTO — Smoking pot can be a mixed blessing for epileptics.

A recent study reported in the *Medial World News* (Aug 20) claims pot can either produce fits in epileptics or curb them, depending on the amount inhaled, its potency, and the frequency of the epileptic's seizures.

Dennis M. Feeney, professor of psychology and physiology at the University of New Mexico, said at the annual meeting of the American Council on Marijuana in New York:

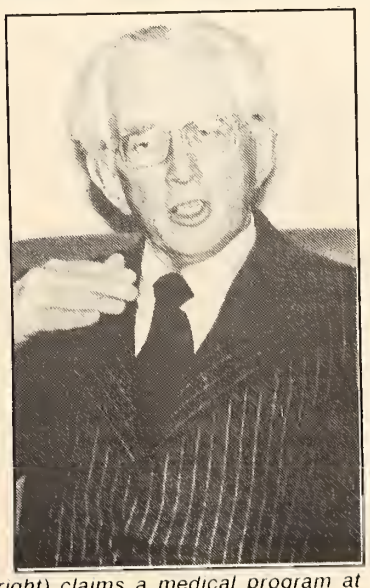
"Marijuana is like a cannabinoid cocktail, with different components affecting different mechanisms of epilepsy."

Dr Feeney hypothesized from laboratory evidence that cannabinoids cause fits by stimulating high-voltage brain waves. They also hinder the spread of high-frequency neuronal firings, which curbs the fits.

Two other experts, who asked to remain unnamed, told MWN that the opposite effects may be explained by the fact that most anti-epilepsy drugs control certain types of seizures while exacerbating others.

Dr Feeney said his experience indicates that half the epileptics under 30 use pot. He advised epileptics not to use it because it is most likely to trigger convulsions in persons whose disorder is under relatively good control — the majority of epileptics.

MDs, patients tell senators of Valium abuses



US Senator Howard Metzenbaum (right) claims a medical program at Cornell University is geared to propagate use of Valium, in senate subcommittee headed by Senator Edward Kennedy.

WASHINGTON — The tranquillizer Valium (diazepam) is over-prescribed by doctors and is potentially addictive in even moderate doses, a panel of doctors has told United States legislators.

Testimony by the doctors as well as patients and doctors who had become addicted to Valium, and by the President of Hoffman LaRoche, the pharmaceutical manufacturer, was presented to the Senate Health Subcommittee headed by Senator Edward Kennedy. Senator Kennedy is sponsoring a bill which would require more information be given consumers on effects of the drug.

Valium is taken routinely each year by 15% of the US population. Some 53 million prescriptions for Valium and 14 million for it's companion drug Librium (chlordiazepoxide), are written each year by American doctors.

Dr Richard Crout, director of the Bureau of Drugs in the Food and Drug Administration (FDA), told the hearing "the average person dealing with the ordinary stresses of life does not need these drugs."

Dr Nelson Hendler, of Johns Hopkins Hospital, Baltimore, said tests have shown that three-quarters of his patients suffered memory loss, intellectual impairment, and disorientation, even when they were taking Valium in low doses.

Senator Howard Metzenbaum charged that Hoffman LaRoche has underwritten a $4 million continuing medical education program at Cornell University aimed at propagating the use of Valium.

Robert Clark, president of Hoffman LaRoche, said the testimony to the senators, of patients and doctors who had become addicted to the drug "are in no way typical of the experience of most individuals who are treated with Valium. We do not deny the existence of some misuse but we do insist that the beneficial effects of Valium far outweigh its detrimental effects."

Mr Clark said his company is now holding discussions with the FDA on better ways to inform consumers and doctors of the potentials for abuse.

Senator Kennedy said "thousands of Americans are hooked and don't know it. The impression is that withdrawal from this drug causes excruciating anxiety, pain, and suffering, but these patients had very little awareness of this as did those in the medical profession."

NEWS

Antabuse, Temposil risky with alcohol...

By Jon Newton

TORONTO — John Peachey, 43, research psychiatrist and a consultant-physician examining problems associated with the administration of Antabuse and Temposil, is convinced there are grounds for concern. Although the two compounds undoubtedly have a place in therapy, he says, they have probably been incorrectly used since their introduction in 1940 (Temposil) and 1956 (Antabuse) respectively. (See page 1).

"I started my studies into both drugs at the foundation in Kingston in 1976," he told **The Journal**. "I was working in collaboration with Dr Jim Briens, and the late Dr Robert Gibbons who, although he was not actively engaged in the research, put up many of the ideas which got us started."

He said until recently there had been no clinical studies into the Temposil/alcohol interaction in humans.

"I think I'm safe in saying that until the last few years there have been no investigations into this aspect, nor into physiological changes like heart rate, blood-pressure, symptom alterations, and so on," he stated.

"But we are very concerned that if a person drinks on either of these drugs, the interaction with alcohol could be life-threatening."

Antabuse and Temposil have been around for many years, initially as chemicals used in different industrial processes.

Hints of a possible application for Temposil as a drug for use in aversion therapy came in the 1920s when French researchers first described the "Mal Rouge" syndrome.

Laborers at factories making fertilizers, in which Temposil was an ingredient, reported extreme nausea after spending all day in the plants, and then drinking after work.

Their symptoms included flushing of the face, shortness of breath, palpitations, and sickness.

Antabuse hit the headlines in the late 1940s, and was associated initially with some marked side-effects, including the death of several patients. Only one instance,in 1963, has been reported of a death attributed directly to Temposil therapy.

"The mechanisms of action for both drugs are due to the inhibition of the aldehyde dehydrogenase enzyme responsible for breaking down acetaldehyde, the first major metabolite of alcohol," explained Dr Peachey.

"Ordinarily, acetaldehyde is rapidly metabolized when a person drinks. But this does not happen when a patient is on Antabuse or Temposil. If he drinks, he becomes violently ill.

"The difference between the two drugs from a therapeutic point of view is the time of onset of their actions, as well as the duration of protection."

Dr Peachey explained that Antabuse exerts a clinical effect about 12 hours after ingestion. The effects, though, can continue for many days.

Temposil, on the other hand, acts very rapidly. Normally an interaction will occur within an hour of a dose being administered, but the duration is relatively short. Protection lasts only between 24 and 36 hours.

"One of the difficulties with Temposil is it is not easy to predict what kind of reactions might be experienced by individual patients," Dr Peachey said.

"There is an appreciable variance in these and in their severity and duration. They can range from minimal to severe and can include a sudden and extreme drop in blood pressure.

"We have found recently that there is also an appreciable difference between the reactions of the same individual over a period of time. For example, in one of our studies, the same amounts of alcohol were given to the same man on three different occasions. His first reaction was severe, the next not quite so bad, and the third, minimal."

Dr Peachey said there were also fears that both drugs — but Temposil in particular — could be used by patients not to halt their drinking, but to enhance it.

Some individuals reported being able to "burn off" Antabuse by a conscious effort of will. And there were others, on Temposil, who seemed to show a rise instead of a drop in blood alcohol levels.

"Even though these drugs have been in use for many years, I feel it is time to thoroughly re-evaluate, if not re-think, their application in the treatment of alcoholics," he said.

"We know too little about their long-term effects to be able safely to prescribe them over long periods of time, and there are also indications that they should be used only as adjuncts in therapy, not as a means to an end."

In his view, patients should be assessed medically before being put on a program which includes the prolonged use of Antabuse or Temposil. And, more importantly, he believes the drugs should only be used in conjunction with other forms of treatment and then gradually discontinued.

"I would certainly suggest that any doctor who is contemplating the use of either drug should give his patient a thorough check up first," stated Dr Peachey.

"This should include a biochemical profile, and liver screening to discover any abnormalities which do, after all, occur frequently in alcoholics.

"And doctors and therapists may not be aware that Temposil inhibits and prevents the formation of thyroxin, the thyroid hormone, so thyroid function tests should be included in the screening to make sure patients are not borderline hypothyroid.

"One of the many problems associated with these drugs is we do not know for sure what their contraindications are, or indeed what their indications are," continued Dr Peachey.

"Extensive cardiovascular examinations should be made, and an EKG should also be carried out.

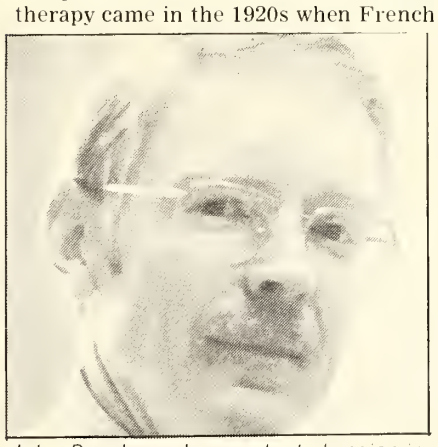
"In addition, the medical and biochemical tests should be repeated during the time they're being used. I would go further and say we would recommend biochemical tests at least every two or three months for the duration of the treatment, and heart tracings should be done at least every six months.

"I doubt whether this is common knowledge and I would be surprised to learn that there is an assessment done as a matter of routine before Temposil or Antabuse are prescribed. It is not unusual to find patients who have been taking the drugs for a number of years without ever having been tested for possible medical complications."

He also had a warning for family practitioners. It would not be out of the ordinary to find a patient already on one of the compounds, and receiving repeat prescriptions ad infinitum, without his doctor being aware of the possible harmful long-term effects.

"One might also want to see much more frequent checks made over the first month to six weeks of treatment," he said.

"Antabuse, for example, has three active metabolites, and these breakdown products can cause neuropathy, increases or changes in liver function, and possible alterations in neuropsychological function affecting memory recall. So individuals must be carefully assessed and re-assessed at regular intervals."



John Peachey who conducted major investigation into interaction of alcohol and anti-drinking drugs.

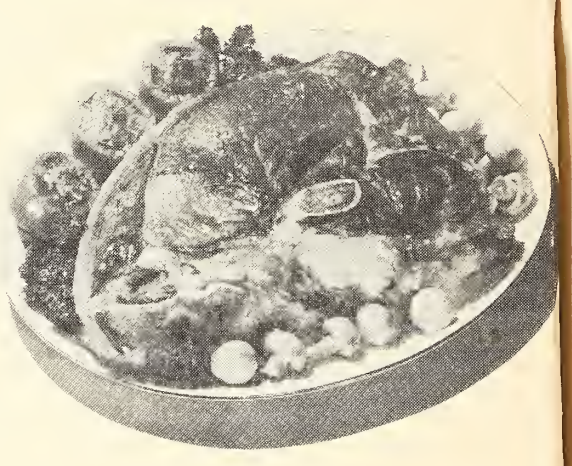
...and so is inky cap mushroom

If your steak and mushrooms cause a violent reaction — nausea after your Chateau Ottawa, a flushed face, and general discomfort — be warned.

You're probably experiencing a reaction similar to that suffered by an alcoholic who tries to tie one on after taking Antabuse or Temposil.

Dr Peachy says the inky cap mushroom, when taken with, say, an unpretentious little Beaujolais, has an effect similar to Temposil's when taken with a dram.

"The active ingredient of this mushroom was only recently identified," he said, "and its action is almost identical to Temposil's."



Joint conference seen as way to close the rift

(from page 1)

create an effective coalition."

Ron Gaetano, NDC chairman, said "the groups very much want to work together and the field is moving towards coming together."

Mr Jensen said the ADPA will keep its separate corporate status but will be part of the corporation which will run the annual meetings. "We wanted to get to know each other better for a broad based constituency, but in terms of distinct corporate goals, it is up to each group."

The meeting last month was a result of leaders in the field trying to reconcile groups whose separation has been costly in a number of ways. Final figures indicate there were some 800 delegates attending the NDAC meeting in New Orleans and 400 at the NDC meeting in Washington. Only the ADPA had its expected 900 member attendance.

Mr Jensen, Mr Gaetano, and Dr Pollin spelled out the situation both in addresses to the delegates and in interviews with **The Journal**.

Dr Pollin believes the drug abuse field in particular has reached a plateau after a period of explosive growth and this has produced "uncertainty, pessimism, fatigue, and drift that always characterizes the end of a period of rapid growth."

The split has some healthy aspects but there is the danger "of positions becoming solidified in a posture of self-destructive opposition." However, there is an awareness on the part of many leaders "that the priority need is for the field to reunite itself."

Dr Pollin emphasized that NIDA "cannot appropriately, as a federal agency, impose unity. But there are three steps we can take:

"The first is to emphasize and clarify the importance of the issues and dangers of the present splits. The second is to keep the attention of the leadership of the separate groups focused on that threat.

"Thirdly, I think we have to explore very actively what are the administrative options available to us, so that in addition merely to calling attention to the problems, we can see what actions we can take in terms of funding, and not funding, conferences next year to reinforce the importance of arriving at some kind of unity."

Dr Pollin pointed out it is quite possible for ADPA, NDC, and NDAC to hold co-located conferences without federal support. But if federal support is sought "we will in terms of considering future funding, to the extent possible, build in evidence of a move towards unification as one of the significant criteria."

Dr Pollin acknowledged it does not help the image of the substance abuse field to have such a split, particularly in Congress. The positive aspect is that "it takes episodes of this kind for a field or for individuals to recognize what are the dangers and opportunities and then to get the priorities together."

Mr Jensen is in no doubt about the immediate future: "I think we are in one of the most critical times in the history of the drug and alcohol field in this country."

There have been major changes in leaderships of the institutes and on the Congressional committees which deal with the substance abuse field. In addition there is the pressure for block grants in place of categorical funding.

Mr Jensen said: "Considering the block grant idea, at present the individual components are not strong enough to withstand the pressure. This could mean millions of dollars would be lost, programs would be closed and clients would not be served because they are not served adequately in the traditional system.

"It is the absolute responsibility of anybody and everybody who has anything to do with the split between NDAC, NDC, and ADPA to work together. We in ADPA want to bring the constituencies together so we can understand each other and work out a common front on key issues in the drug and alcohol field.

"We have to put our partisan issues aside and deal with this field. In unity is strength."

On the practical level, "it is ridiculous for three different organizations to have meetings all across the country, running people back and forth. We have to get it together. There is no drive for one group to swallow the other."

Mr Gaetano said: "It is of the greatest importance for the field to come together. There is no doubt in my mind that people out there need us."

He finds that "what is out there is not only ego trips of individuals but also ego trips of power groups.

"I don't see a lot of hope for us, I really don't, until we decide what power is. It could truly be survival in the 80s.

Alcoholics' sex lives need help

HAMILTON — The alcoholic's sexual relationships are usualty just as disrupted by his or her drinking as other aspects of life, and sex therapy should be part of the rehabilitation program, says a Donwood Institute physician.

"Sex therapy can serve as a unifying force for a couple that has not had the experience of working together as a loving team for quite some time," Jan Dowsling told the annual Institute on Addiction Studies here. She is coordinator of medical services at the Donwood, an alcoholism treatment centre in Toronto.

"Most importantly, it can reinforce sobriety and improve a patient's chance for recovery by supporting the benefits of a chemical free lifestyle, resulting in a healthy, human sexual response.

"The alcoholism and sexual problems have had a detrimental effect on family life, and because family support is so important to recovery, sexual recovery is essential. Sex should be viewed as one more aspect of communication which may need attention."

At her centre, where sex therapy is offered as one modality of the program, they find most recovering alcoholics who complain of sexual dysfunction do not have a clear-cut organic basis for it.

"It is important to stress that the most important and most common type of sexual problem found in both male and female alcoholics is the inability to maintain satisfying, intimate, and meaningful relationships. This inability is probably related to the nature of the disease itself and to its consequences," Dr Dowsling said.

Self-esteem

For the woman alcoholic, damage to self-esteem is a major problem, and this affects her sexual response. She does not become sexually impotent from drinking, but it can take its toll on her attractiveness and desirability.

Male alcoholics, too, have self-esteem problems, but in the chronic stage it is often associated with loss of libido, erectile problems, impaired sperm production, and testicular atrophy.

"These changes may be directly related to the toxic, physical effects of alcohol."

In the recovering alcoholic, depression, stress, and fatigue are common complaints that can profoundly damage sexuality.

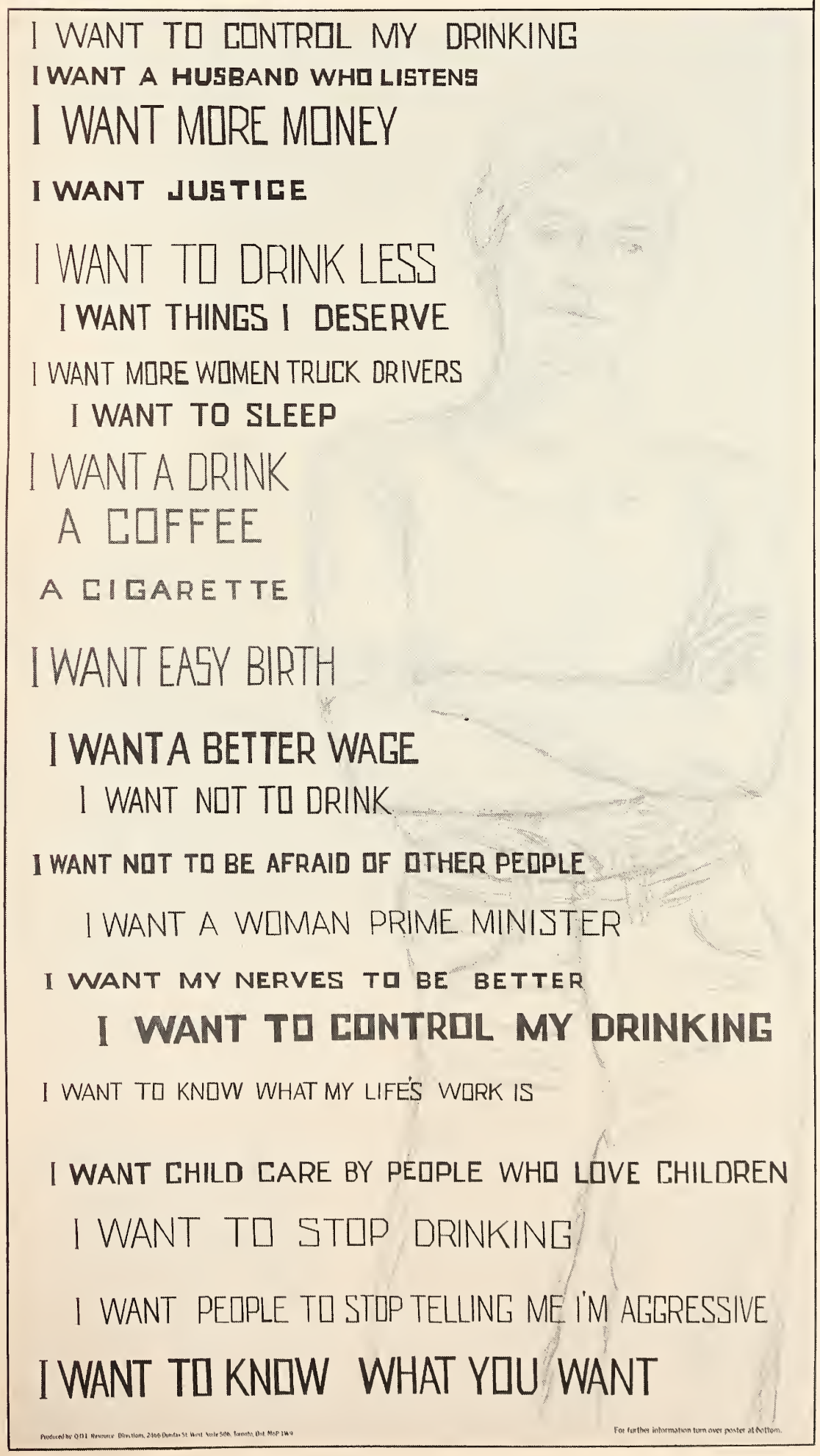
Fear of failure

"Fear of failure is at the base of many sexual problems and is especially relevant to the recovering alcoholic who has usually experienced many sexual failures. Erotic feelings are frightening to many people, and especially to the recovering alcoholic, who has used alcohol to dull sensations in the past."

Dr Dowsling said it is essential that treatment professionals not only have a basic understanding of the complex field of sexuality, but "an appreciation of the wide range of normal sexuality and a tolerance for attitudes which differ from our own. Our usefulness as therapists is greatest only when we recognize how our own attitudes influence our therapy."

A woman's quality of life...

One of three posters addressing issues of women and their health prepared by QOL Resource Directions with support from the Health Promotion Directorate of Health and Welfare Canada. The posters are being distributed throughout Canada by QOL and the directorate through its regional offices. They are available on request from QOL Resource Directions, 2466 Dundas St West, Suite 506, Toronto, Ontario M6P 1W9. QOL (quality of life) is a non-profit organization examining social policy and producing educational resources concerning women.



Some halt alcoholism with suicide: study

OTTAWA — Alcoholism has been described as a form of chronic suicide. But some let the disease run its course while others terminate the process by taking their own lives, according to Paul W. Haberman, senior research associate, Columbia University School of Public Health, New York.

Reporting a study at the 10th International Congress for Suicide Prevention here he suggested white married alcoholics in the labor force are at high risk for *suicide* while single, black alcoholics whose principal activity in the year before death had become drinking or doing nothing, die more often of *chronic alcoholism.*

One reason for the different routes taken, he speculated, was that in this study the employed and married Caucasians more frequently had spouses, relatives, and employers who objected to their drinking; whereas the male, unemployed or little-employed black chronic alcoholic, faced less conflict as a consequence of his drinking.

His data came from a study of 1,954 suspicious deaths of people 18 years and over investigated by the Office of the Medical Examiner, New York City. He also used a questionnaire filled out by a relative or other informant, autopsy, and toxicologic results. Of the 1,954 deaths, 263 died of chronic alcoholism and 61 alcoholics committed suicide. The impression of the medical examiners was that almost all of those who died of alcoholism suffered chronic symptoms of the disease, while most of the alcoholic suicides had signs of mental illness, particularly depression.

The most common means of suicide were jumping from heights and taking an overdose of pills. These methods were used by almost one-third of the victims, followed by shooting, hanging, and jumping in front of subways.

Pill-taking was the most common means among women, whites, and older people, and men, blacks, and younger people jumped from heights more often. Alcoholics and narcotic abusers were somewhat more likely to use pills to take their lives than were non-abusers.

Among homicide victims, Mr Haberman found that almost 50% were substance abusers — mainly alcohol.

"Likewise, almost three-tenths of all suicides and motor vehicle fatalities, and two-fifths of other accident victims, were alcoholics, narcotic abusers, or both.

His data also revealed that suicide and alcoholism as well as homicide and narcotic addiction, as causes of death, run in families. This supports findings in the literature that suicide rates for relatives of suicide victims are two to three times higher than those for the general population.

Toronto gets bigger RIDE

TORONTO — A pilot project to reduce impaired driving in a Toronto suburb has been extended to the entire metropolitan area of 2^1_4 million people.

The decision to enter phase two of RIDE, (Reduce Impaired Driving Everywhere), was largely a result of favorable media reaction to its successes in Etobicoke, according to Allen Nield of the Addiction Research Foundation (ARF) initiator and general coordinator of RIDE.

"Over 250 enthusiastic articles and editorials in the last 18 months alone suggest there is a lot of public support for RIDE," said Mr Nield. "That makes us anxious to extend the program."

RIDE began in October, 1977, as Reduce Impaired Driving in Etobicoke. It was a joint project of the ARF, the Etobicoke Safety Council, and the Metro police. It included community education on drinking and driving and a high visibility enforcement campaign utilizing random roadside spot checks. (**The Journal**, Nov, 1977)

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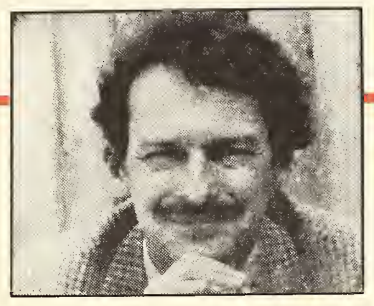
A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.



GILBERT

'. . . One conclusion might be that cigarettes should be made stronger, not weaker, in order to provide the maximum deterrent to a would-be regular smoker. . .'

Why do people smoke?

By Richard Gilbert

The simple answer is that we don't know very much about why people smoke tobacco.

There are really five distinct questions to answer:

Why is the first cigarette smoked?

Whatever causes a hapless child or adult to draw on a cigarette for the first time, it cannot be a previous positive experience of smoking. In some cases the novice is incited to smoke — by parents, believe it or not, or by peers or older children. More often the first cigarette is sought out, to conform or to experiment. In either case the result is usually unpleasant, although less so in recent years because available cigarettes have become milder.

Why are the next few cigarettes smoked?

Given the near certain aversiveness of the first encounter with tobacco, the social or other pressures that cause the second, third, and even the 15th cigarette to be smoked are likely even stronger than those that caused the first.

One study that needs repeating found that of the three-quarters of British teenagers who smoked more than one cigarette in the 1960s, 85% became regular smokers. Even though tar and nicotine content were high compared with today's Canadian cigarettes, social and other factors were sufficient to overcome the aversive first experience.

Studies of recruitment to smoking should focus on the next few cigarettes after the first. We know that teenagers are more likely to smoke if parents or friends smoke, and if they have left school or are in non academic streams. We don't know how these factors work to overcome the aversiveness of tobacco smoke. One conclusion from further work on smoking the second cigarette might be that cigarettes should be made stronger, not weaker, in order to provide the maximum deterrent to a would-be regular smoker.

Why does the number smoked each day increase and then level off?

After the first few dozen cigarettes, substantial tolerance develops to many of the effects that make the novice smoker ill. Social and other pressures to increase consumption do their dirty work with less opposition from the victim's body. Indeed, the body now becomes an ally. Cigarette smoking can be pleasurable — a point overlooked by many researchers. Pleasure and pressure combine to achieve a steady increase that, in most smokers, levels off at between 15 and 25 cigarettes a day.

Physical dependence on nicotine enters the picture at about 10 cigarettes a day, perhaps less for teenagers because they may be smaller and because, in Canada at least, they tend to smoke stronger cigarettes than adults. Dependence can play no part in the early transition from experimentation to regular smoking. It probably plays but a small part in the subsequent escalation to a plateau. Dependence is most important as a barrier to reducing consumption below the 10-cigarette threshold, rather than as a cause of maintaining consumption at around 20 cigarettes a day.

As consumption rises from one or two a day, various factors limiting consumption also grow in importance until they are sufficient to stabilize smoking at a plateau, perhaps after some years. The cost of cigarettes can be an important restraint for young people. Opportunity to smoke is another. A too rapid escalation of use can revive the unpleasantness of the first few cigarettes, acting as a further check on smoking. Obvious signs of disease — morning coughing, for example — can restrain excessive smoking, even in a teenager. Social pressure to quit becomes a factor, although few teenagers succumb. Curiously, whereas adult women find it generally more difficult to quit than men, for teenagers the reverse seems true, a fact whose investigation might produce powerful insights into both sex differences and smoking.

Why does smoking continue in spite of obvious discomfort, disease, and desire to quit?

The most astonishing fact about smokers is that most of them say they would prefer not to smoke. Among adult regular smokers in Canada, 60% or more try to quit at one time or another. Of these, less than half are successful. Thus most smokers, including the minority who do not try to quit, smoke until death, which usually comes earlier because of their smoking.

The main barrier to quitting is physical dependence on nicotine, which, according to some studies, is more powerful than dependence on heroin, alcohol, and other drugs of abuse. Our ignorance of how this dependence motivates continued smoking is immense.

Why, after quitting, do people start smoking again?

The brighter side of smoking is that, in Canada, some 27% of sometime regular smokers appear to quit before they die. Nearly all of these do it without formal help. If we knew how these quitters succeed by themselves, we might be in a better position to help the small minority of would-be quitters who seek some kind of professional aid.

Of those who try to stop, however, more than half relapse. Treatment works, but usually not forever after. Willpower works, but it is needed again and again. Why, after a year or more without a cigarette, will an erstwhile smoker succumb? Tolerance has been lost; the first cigarette is nauseating. It is also a conspicuous admission of defeat in a society that continues to value success and increasingly values abstinence. But the former smoker is now a smoker again.

Recent research suggests that craving for a drug can be conditioned to particular sets of environmental events and internal states. The drug is unused, but it leaves the legacy of a dormant craving ready to be aroused if the right circumstances occur. Anxiousness, alcohol, and a smoky bar could be such a trigger, and the first cigarette after a year's abstinence can be the trigger for more craving that leads to the second, the third, and so on.

This conditionable craving is not strictly psychological, because it depends in the first instance on the pharmacological properties of the drug; its physiological concomitants can be as substantial as those that accompany the craving that arises from simple absence of a regularly used drug. Conditionable craving means that cigarette smokers forfeit control over some of their behavior to their environment, forever. A former smoker lives in a world of temptation. It is better not to have begun; but it is difficult to convince a smoking teenager that shackles are being forged.

The last words

These should come from Dr Lynn Kozlowski, a recently appointed scientist with the Addiction Research Foundation of Ontario, and author of the chapter on *Psychosocial Influences on Cigarette Smoking* in the US Surgeon-General's 1979 report. I asked him: "Why do people smoke?" He replied "We'll never have a simple, one-reason answer. Smoking is addictive and is supported by a menagerie of biological and psychosocial rewards."

Next month: A case for tobacco advertising

ARF's Israel continues pioneer PTU work

Examination, evaluation still to be done

By Jon Newton

TORONTO — Tucked away on the third floor of Toronto's Addiction Research Foundation (ARF) headquarters is the office of Yedy Israel, biochemist, professor of pharmacology at the University of Toronto, and biochemical researcher.

A calm, quietly-spoken man, Dr Israel is also director of ARF's clinical institute and already well-known to workers in the field of addiction research.

But, a recently completed study on the effects of propylthiouracil (PTU) in treatment of alcoholics with severe liver damage, and a second long term project begun a year ago, have put his name even further forward.

With colleagues Dr Hector Orrego, principal investigator at ARF's clinical studies unit, Dr Laurence Blendis, gastroenterologist at Toronto General Hospital, and Dr Harold Kalant, associate research director, biological studies, Dr Israel has been an important contributor to the two projects which — while they were primarily to investigate the treatment of alcoholic liver disease — have also opened the way to a new source of physiopathological knowledge.

The story began in 1970 when Dr Israel and fellow workers were collating evidence of the effect of alcohol on the livers of rats. The animal model was devised to look at the role of alcohol in specific liver conditions promoting the development of fibrous tissue against that of healthy tissue.

"The livers of rats treated with alcohol showed chemical changes similar to those found following the administration of large doses of thyroid substances," he said. "PTU is an anti-thyroid drug which, for the last 40 years, has been used to treat hyperthyroid complaints, angina, and several ischemic heart conditions where there was a lack of oxygen."

It has since been replaced by other drugs more suitable for heart conditions — but following the work by Dr Israel and his team, PTU may have a new application.

Previous ARF studies show animals on large doses of alcohol undergo metabolic changes which rely on the thyroid hormone, but which can be blocked by PTU.

More recent investigations indicate PTU can also act as a barrier against hypoxic liver disease in rats treated with alcohol and ureogenic aminoacids. PTU was also found to protect rats against damage to their livers caused experimentally by carbon tetrachloride.

'We are very encouraged by the results so far'

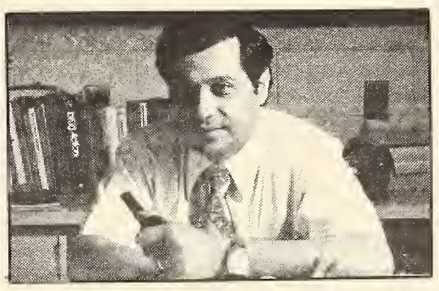
The first study, involving 140 alcoholics divided into two groups, aimed at examining PTU's effectiveness in treating people with alcoholic liver disease. And the results were promising, to put it mildly.

Half the groups were given placebos, and the remainder, PTU. The former progressed normally, but the alcoholics on PTU (most of whom were still drinking) showed a recovery rate of twice that seen in the placebo controls.

The object of the second, long term test is to determine if mortality is reduced and whether patients on PTU have improved significantly over the controls. The project was financed by a $30,000 grant from the provincial lottery and will continue for at least another two years.

Dr Israel explained: "We are very encouraged by the results so far. We have seen patients presenting with livers so badly damaged by alcohol that they could not produce the molecules which enable the blood to clot.

"But, following treatment with PTU (the usual time span was 42 days) their liver conditions definitely improved. Furthermore, we were able to check off 15 other different items associated with liver function, and the improvements



resulted directly from the administration of PTU.

"But it cannot help people with inactive complaints, like cirrhosis. However, patients with active disease, like hepatitis, may be aided and the treatment could also help prevent hepatitis from developing into cirrhosis."

At this stage, PTU can only be used in an experimental situation and Dr Israel hopes things will remain that way until the second study is finished, and the results analysed.

"At the moment we have about 80 patients involved in the second program," he continued, "but we want to expand this until some 150 are taking part. The doses of PTU are relatively low — 300 mg — but it will not be generally available for some time to come."

Hc explained that his colleagues, Drs Orrego and Blindis, are playing a major part in this program.

Put very simply, PTU reduces oxygen consumption of the liver, enabling the same amount to be made available to *all* liver cells, instead of just those in the immediate area.

Information gathered on patients in the first study group treated with placebos, observations on the correlation between histological diagnosis and liver cell function, and the effects of liver cell disease on thyroid hormone metabolism, together comprise extremely important advances in understanding the clinical pathology of alcoholic liver conditions.

The short term study is already in the literature and available to workers.

"But at this point we are not pushing the use of PTU," said Dr Israel. "We could not yet recommend it for general use, but we hope this situation will change once we have thoroughly examined and evaluated PTU."

Aged 39, Dr Israel was born in Chile, but has been in Canada since 1962, except for a three-year spell at the National Institute for Health at Bethesda, Md, USA, and another 12 months at the University of Chile's department of biochemistry at Santiago.

And here he intends to stay. "Canada is a truly fantastic country," he added, "and working at an institute like ARF, which is unique in the world, is a privilege."

When he is not directing research projects at ARF, Dr Israel teaches advanced pharmacology at the University of Toronto: his involvement there means potential workers in addiction research get early exposure to the work of Dr Israel and his many colleagues.

In fact, the PTU study has already netted three graduates currently working in different areas of liver and alcohol research.

'Use reached crescendo during period of stress'

Senay studying polydrug intake murders

By Harvey McConnell

CHICAGO — The young man, within 72 hours, took six grams of cocaine, 30 drinks of alcohol, smoked 30 marijuana cigarettes, ingested 30 to 40 methaqualone tablets, and then, with no previous history of violence, committed a poorly thought out murder.

This estimate of the murderer's intake was made following extensive interviews with the man by Edward Senay, executive director of Substance Abuse Services in Chicago. Dr Senay is currently writing a monograph on this and a dozen similar cases of murder following a very high drug intake, usually including cocaine or phencyclidine (PCP).

The writing is sandwiched between his work with addicts in Chicago, where "Ts and Blues", Talwin and Pyribenzamine,

Edward Senay: the murders were out of character and disjointed — completely incongruous.

are a major problem and one with signs of spreading to other cities.

He is also active in work with the World Health Organization (WHO) and, some months back, advised delegates from a number of developing countries on how they might tackle drug abuse problems. Specifically, he told them not to copy the North American way.

Dr Senay's experience as an expert witness in court is the basis of his monograph on stimulant murders. Before testifying he interviewed the defendants for several hours.

"I found a common ground: an extremely high level of polydrug intake over a number of months which reached a crescendo during a period of stress. Murder is committed and then the murderer feels remorse, which I think is genuine."

The course of action is historically akin to that in murders committed when high doses of amphetamine were involved.

Most of the killers have been young cocaine dealers, who used their own illegal products, and who became very agitated and frightened when they moved into the territories of other dealers.

In the case Dr Senay investigated most recently "the murderer helped his victim off with his coat in a polite manner — this was witnessed — and then in the next two or three minutes proceeded to kill him in an extremely violent attack. This behavior was followed by genuine appeals for help for the victim."

None of the murderers had a previous history of violence and their acts were out of character and disjointed. In addition, all of them suffered from complete amnesia about the murders.

"From the clinician's point of view, it is the juxtaposition of behaviors completely incongruous one with the other," Dr Senay adds.

The biggest public health problem for Dr Senay in his work, however, is the widespread use of "Ts and Blues" among an estimated half of Chicago's heroin addict population.

The combination they take intravenously is pentazocine (Talwin) and tripelennamine (Pyribenzamine).

"Drugs don't usually spread out from Chicago, but in this instance it seems to be the case. It has been a serious problem here for two or three years and I have now heard reports of its use in Detroit and Philadelphia," notes Dr Senay.

He finds this usage "a pretty weird thing, because pentazocine has narcotic antagonist properties and, given to people who have an active habit, would precipitate narcotic withdrawal.

"What is peculiar are reports by regular street users of heroin that this combination of Ts and Blues does take off 'the sickness,' as they say, so I don't know that I really understand it at all."

He does know it is much easier to detoxify a person taking Ts and Blues than one taking heroin, which is why he opposed the Food and Drug Administration decision to put pentazocine on schedule two. "I would rather have a trivial detoxification problem than a more complicated one. I am worried that when the pentazocine market dries up, they may go back to heroin or a more serious habit."

Dr Senay admits he has definite opinions on the question of heroin maintenance: "I wish we could go ahead and try it so that we would find out it doesn't work, and then we could go on to the next step."

At the same time, he believes the use and distribution of heroin for maintenance would create enormous problems, and would certainly not end the illicit market if heroin were made legal.

At a recent conference in Alexandria, Egypt, Dr Senay, an advisor to WHO, tried to assist delegates from a number of Middle Eastern and Asian countries to work out ways to tackle increases in drug abuse.

He advised them to integrate drug abuse treatment into the general health care system and not make the mistake of the US in creating a separate system of treatment.

Dr Senay: "These countries will never have enough doctors working in the countryside and they have got to have some kind of feldscher system. I advised that elementary training in drug abuse should be part of the system."

He found most delegates were dismayed at the attitude adopted by many in the West concerning cannabis.

"They were very upset with Western opinion that sounds to them like cannabis is a vitamin and is good for you."

Dr Senay feels that in the US the drug treatment system is in for rough times. Although it was politically imperative to build a system quickly, "the services we built were very shaky and we are starting to reap the harvest of this.

"Many methadone clinics, even those that function pretty well, are coming under hard attack from many places. If we had built the system more slowly and brought it along in an ordered way, we would be much better off now."

INTERNATIONAL

Thomas Land reports:

Loosening of drug laws angers Asia

GENEVA — The major Asian producers of illicit drugs flooding the black markets of Europe and North America have warned the West against undermining their efforts to stem the tide.

Behind closed doors

I understand their warning was delivered at a recent conference held behind closed doors by the United Nations' International Narcotics Control Board here in Geneva. The 17 Asian countries taking a joint stance against half-hearted law reforms in the West include Thailand, Nepal, Hong Kong, and Malaysia, all of which are involved in international efforts to control the trade. And their views may well be supported by other countries at the receiving end of Western exports of organized crime resulting from conflicting moral and legal attitudes towards cannabis.

For the current trend in Western Europe and North America to more liberal cannabis laws is "an active encouragement" to expanding illicit production, as well as smuggling and related crimes in other parts of the world, according to a joint statement issued by the national narcotic law enforcement agencies of the Far East.

The statement was published after confidential deliberations by the operational heads of the agencies in Colombo late last year. Their politely worded document describes a legitimate and growing anxiety.

Moves in the West toward decriminalizing cannabis have created a vast, semi-legitimate market for the drug without a legitimate source of supply. And the high financial returns offered by the market have attracted criminal suppliers dealing in several commodities . . including heroin.

There is increasing political pressure in many West European countries to follow the lead of the United States where many states have opted for legal reform, reducing penalties for possession of small amounts and making it a non criminal offence similar to a traffic violation.

But one by-product of their reforms, in the absence of a legitimate source of cannabis supply, is the proliferation of crime elsewhere. In Colombia, for example, drug dealers supplying the North American market have turned the northern coastal regions into an enormous, illegal cannabis plantation. The attorney-general's office there recently estimated that 175,000 acres had been planted with cannabis in the foothills of the Sierra Nevada de Santa Marta, yielding a quality produce worth more than $20 an ounce to connoisseurs, according to one authoritative observer.

'The cannabis bonanza'

As he put it: "Colombia suffers from the cannabis bonanza in many ways, including the corruption brought by an illegal national income of up to $4 billion and the violence in its wake. Some towns on the Santa Marta 'Golden Triangle' have a murder rate 50 times that of the none-too-peaceful capital of Bogota."

In their statement, the law enforcement chiefs of the Far East jointly asked the specialist UN organizations to "urge all governments and agencies involved to take full account . . . of the desirability of maintaining consistent action (and) to discourage the spread of cannabis production, consumption, and trafficking".

They observed that many countries still regard cannabis use as "a major and serious offence constituting a social and sometimes economic hazard" and, unlike the West, some of them have recently increased penalties both in severity and scope. They complained that a change of policy in the rich countries encouraging the illicit drug traffic can only increase the burden of the law enforcement authorities in the rest of the world.

Alcohol is enemy in German forces

Alcohol abuse is to blame for sharp increase among soldiers in West German forces of drunken driving, rape, murder, and general violence, says a report by the country's "ombudsman" for military affairs.

By John Dornberg

MUNICH — Alcohol abuse is becoming a major problem in the West German armed services, according to parliament's special "ombudsman" for military affairs, Karl Wilhelm Berkhan.

During the past two years, according to a recently released report by Mr Berkhan, there has been a 138% increase in cases of drunken driving involving West German servicemen; a 179% rise in alcohol related cases of crimes of rape, murder, and other forms of violence; a 257% jump in absence-without-leave due to excessive drinking.

The defence ministry itself, which has sought to play down the significance of the Berkhan report, admits to 5,750 disciplinary cases "where alcohol was a factor" among West German soldiers, airmen, and sailors in 1978.

As a result of widespread public discussion of the report and publicized cases of rowdy, drunken behavior by servicemen, especially on the railroads at weekends, the defence ministry has issued a number of stern prohibitionary decrees which are surprising only for the fact that they have been standard operating procedure in other armed services of the NATO countries for as long as anyone can remember.

Effective July 1, 1979 there must be strict abstention from alcoholic beverages during duty hours. In addition, unit and base commanders have been authorized to ban consumption after duty and on weekends if they consider "drinking inimical to the performance and defence capability" of their units.

Concurrently, the defence ministry has stepped up military police patrols at major railway stations in key garrison towns on weekends.

The ministry has also contracted with the Freiburg University Medical School to conduct a survey and study among 4,000 representative West German servicemen to determine alcohol consumption habits.

Drinking has traditionally been an attribute of, and problem in, German armies. During the days of the kaiser a "good soldier" was one who could drink his rank peers and superiors under the table. And the records show alcohol abuse was also a problem facing commanders during the Third Reich and World War II.

The German inclination to regard beer as a good, instead of an alcoholic beverage, and to spike it with schnaps may be one of the factors.

According to Mr Berkhan's office, there are numerous cases of platoons and companies going on maneuver and alert in which soldiers have filled their field canteens with whisky and gin instead of water or tea.

Mr Berkhan's annual report on morale in the West German Army is not the first to draw attention to alcohol abuse. His predecessors in the watchdog position, comparable to that of an inspector general, have made similar observations.

From 1971 through 1974, for example, there were 25 fatal motor vehicle accidents in the army involving alcohol consumption while on duty, 161 involving servicemen drinking while under the influence after duty hours.

Chinese women moving to hard drugs

By Anne MacLennan

TORONTO — Five per cent of Hong Kong's 31,000 drug addicts are women and of those, 44% are under 25 years of age.

This is in marked contrast to the situation with men. Of the 96% of addicts who are male, only 17% are under 25.

The figures have come to light with the establishment of the Hong Kong Central Registry of Drug Addicts (The Journal, Sept) **and they are causing some concern, says Peter Lee, Hong Kong's Commissioner for Narcotics.**

The vast majority of the women are Chinese. Traditionally, it has been believed that Chinese women rarely use alcohol or other drugs. Those who have been known to use drugs, said Mr Lee, have concentrated on chemicals — tranquillizers, sleeping pills, etc.

"Now, however, there is growing evidence that heroin is becoming more popular with them," Mr Lee told The Journal. **(Heroin is the drug of choice of 84% of Hong Kong addicts; 11% use opium.)**

He said that most of Hong Kong's registered female addicts are "prostitutes, bar girls, and dance hall hostesses in the 'Suzy Wong' area of Hong Kong."

But, while the numbers now registered and the large number of young addicts may "appear dramatic," Mr Lee suggested there may be a simple explanation.

Peter Lee

"This may, in effect, have been the situation over some years and it is only become apparent now with better record-keeping and increased availability of methadone maintenance clinics.

"A prostitute, particularly a young prostitute, can earn very good money. Earning good money, they can do what many men (addicts) can't. They can go to private doctors and get methadone.

"But, with the tremendous expansion of outpatient methadone treatment in 1976, this became easily available to women as well as men. And what has been revealed now by the registry possibly existed for a number of years."

Nevertheless, the data have sparked some preventive efforts. And a series of messages aimed at women, particularly young women, has been launched by a sub-committee on preventive education and publicity of the Action Campaign Against Narcotics.

The messages, aimed at preventing young women at risk from becoming involved in drug use, and also attempting to alert those already involved to the "dangers," are being broadcast on radio and television and displayed in a series of posters.

One poster message is: Beauty is fragile — don't lose it by taking drugs. Another, with an International Year of the Child theme, features a mother with her young son and the message: His future is in your hands — don't risk it by taking drugs. All messages are in Chinese characters.

German addicts get jail terms, not therapy

By John Dornberg

MUNICH — There is a mounting tendency in West Germany to sentence heroin addicts to stiff jail terms rather than put them on probation during which they can undergo voluntary withdrawal therapy.

This observation was made recently by Reiner Knäusl, a Munich lawyer who specializes in the defence of drug addicts.

Mr Knausl calls it a "dangerous trend," not only in Bavaria but throughout West Germany, and counterproductive to dealing with this country's growing addiction problem.

He cited the case of one 28-year-old Munich man with six previous convictions for violating paragraph 64 of the penal code which makes use and/or possession of a narcotic without a prescription a felony. In the previous cases he was sentenced to brief jail terms on probation.

Arrested again, with about one gram of heroin in his possession, in Munich in Oct, 1978, he decided he had "had enough" and while awaiting trial entered a voluntary withdrawal treatment centre.

Everything indicated the therapy was working, but when his trial came up in July he was sentenced to nine months' imprisonment without probation or a chance to return to the treatment centre.

The court apparently decided it had "had enough," too.

The case, according to Mr Knäusl, is "symptomatic of a trend throughout the country to deal with addicts by penal action instead of psycho-medical treatment and rehabilitation."

One explanation, according to Mr Knäusl, may be the fact that while the number of addicts who have come in conflict with the law continues to grow — currently 60,000 — the number of spaces in treatment centres has remained virtually static at 1,500.

But a general "law and order" mood gaining strength in West Germany may also be a factor.

The irony of the trend is that withdrawal treatment, while expensive, is far less costly then prosecuting and imprisoning hard drug addicts.

Heiner Peterburg, a therapist at the Drug Counselling Center in Hanover, has estimated that an 18-months withdrawal therapy costs approximately DM 40,000 (approx. US $22,000). The costs are generally born by the insurance agencies that comprise West Germany's compulsory health insurance system.

By contrast, says Mr Peterburg, an addict who receives no therapy will probably live to be 30 years old and will cost society around DM 1 million (about US $550,000) in welfare payments, medical care, prosecution, and penal confinement.

The number of deaths from overdoses continues to rise sharply in West Germany this year. In Frankfurt, a major centre of West Germany's heroin trade, with 3,000 known addicts, police on Aug 1 recorded the 28th death from overdose this year. Last year there were 28 deaths for the entire 12 months period.

Pot lobby attacks gov't 'compromise'

By Alan Massam

LONDON — The British pro-cannabis lobby has reacted strongly to the report of the government's Advisory Council on the Misuse of Drugs which urged retention of stiff (although redueed) penalties for possession and trafficking of the drug. (**The Journal**, Aug).

The reply to the recommendation comes in the form of a pamphlet *Trash Rehashed** which says the advisory committee's report was "hopelessly inadequate, full of inaccuracies, and likely only to confuse and mislead both the government and the public."

The pamphlet, published by the group called the Legalise Cannabis Campaign, says: "It is now 10 years since the Wootton Report on Cannabis was published. When the Advisory Council's review was announced in 1977, many people supposed that at last the present working of the cannabis laws would be investigated and that real reform would soon become possible.

"To everyone who held this hope, the council's report has been a total disappointment. We consider this report to be a failure, not only in its own terms, but also in the context of the present demand for cannabis law reform.

"The council has completely omitted any mention of the serious damage caused by the laws prohibiting cannabis both to the more than 10,000 individuals convicted every year under them and to the country as a whole.

"The council themselves admit the penalty reductions they propose (which include the reclassifieation of cannabis and the removal of the magistrates' power to imprison for possession) will make very little difference in praetice.

"Despite assurances made by the government when the inquiry was set up, the much-abused police power to stop and search without arrest is not discussed at all.

"It is clear that the council felt some reforms in cannabis laws are needed because of the mounting evidence about the lack of harmful effects from its use, the change in public opinion towards reform, and the severity of present penalties, now among the highest in Europe.

"But their recommendations are the ultimate political compromise: they will give the government an opportunity to be seen to be cautiously responding to the call for cannabis law reform without having to make any meaningful changes."

The pamphlet goes on to outline the Legalise Cannabis Campaign's proposals for changing the cannabis laws here. These include:

- removal of all penalties for possession and for the cultivation of the drug for personal use;
- abolition of police powers for stopping and searching an individual for drugs without arrest; and
- abolition of the offence of "allowing premises to be used for smoking cannabis."

The campaign also wants to see a legal redefinition of "supply" when referring to cannabis so that it would exclude any non profit exchange; a reduction of penalties for supply offences to a maximum of two years imprisonment (as was urged by the Wootton committee); and the establishment of a public inquiry to investigate the possibility of cannabis being distributed and sold legally.

**Trashed Rehashed. Legalise Cannabis Campaign, 2, Blenheim Cres, London W112EE (01 727 8805) Price 95p.*

Tobacco industries 'pedlars of death'

By Alan Massam

LONDON — The chairman of Britain's National Society of Non-smokers wants to see a much tougher line taken against tobacco manufacturers. "We need to confront them as 'pedlars of death'," Tom Hurst says in the latest issue of the society's newsletter.*

"We should become more militant in our efforts against them. The wholesale murder of innocent people should not be allowed to continue. People are more important than profits."

Mr Hurst, white-haired, and saintly in appearance, is well known for his evangelical zeal. But curiously enough, his latest outburst of indignation seems to have been provoked by attendance at the Fourth World Conference on Smoking and Health in Stockholm.

He tells society members he has attended all four conferences and found that the last was the least satisfactory. "This conference, more than the previous ones, was dominated by talk, talk, talk, and not enough action," he protests.

"In my view, we must look at smoking in the context of:

- The whole person;
- The urgent need to make greatest effort and give priority to people at highest risk, a) pregnant women, b) special occupational exposures, c) people with chest and heart problems."

The newsletter reports elsewhere that Britain's General Household Survey for 1978 showed the decline of cigarette smoking here, which was evident in the early part of the 70s, (particularly between years 1974 and 1976) has become less marked.

Between 1972 and 1976, prevalence fell among both sexes, but was more marked among men (from 52% to 46%) than among women (from 41% to 38%.)

The overall fall in prevalence was due mainly to a fall in the proportions of men and women who were light smokers (fewer than 20 cigarettes a day). "The proportions of men and women who were heavy smokers (20 or more cigarettes a day) remained fairly constant," the newsletter adds.

"So average weekly consumption of cigarettes rose during that period.

"Between 1976 and 1978, prevalance fell only from 46% to 45% among men and from 38% to 37% among women."

(Prevalence is defined as the proportion of adults who smoke cigarettes.)

Meanwhile, the latest bulletin from ASH (The Royal College of Physicians pressure group Action on Smoking and Health) reports Britain's Office of Population Censuses and Surveys has published provisional lung cancer death figures for 1978.

They show deaths from lung cancer, after falling slightly in men in 1975, are continuing to rise in both sexes, although the increase is greatest in women. Over one third of the total deaths from lung cancer in 1978 were in people aged under 65.

ASH further records that tobacco companies in the United Kingdom cut back on their spending on advertising in 1978 although levels appear to have been restored and then exceeded in 1979 (up to June.).

National Society of Non Smokers, 78, Langley Rd., Watford, Herts, England.

Metal union fights on-job alcohol ban

FRANKFURT — A curious controversy has erupted between West Germany's metal workers' union, the largest single trade union in the world, and the metal working industry.

Put succinctly, the debate is whether to drink, or not to drink, on the job.

About 11 months ago, it seems, *Gesamtmetall*, an association of West German manufacturers in the steel, metal, automotive, and machinery sector, put out a circular to its member industrialists calling attention to the dangers of alcohol abuse during working hours in factories and shops.

The circular suggested a complete ban on drinking during working hours on plant properties.

Recently the circular, copies of which apparently reached union officials, was treated editorially in *Metall*, the weekly newspaper of the 2.2 million-member *Industriegewerkschaft Metall*, Germany's —and the world's — largest union.

"A ban on drinking," said Karl Heinz Jansen, a top-ranking member of the union's board "will merely lead to widespread in-plant black marketing of alcohol."

While he did not rule out an alcohol ban for "especially dangerous" jobs and work areas, he opposed "general prohibition" and recommended that "instead of punishment there should be more in-plant counselling."

Germany's metal working union claims on-the-job ban on drinking would lead to in-plant black market for alcohol.

NEWS

AMA to mount attack on tobacco addictions...

By David Milne

CHICAGO — The American Medical Association will mount a broad attack against cigarette smoking and other forms of tobacco addiction, it was announced at the annual meeting of the AMA's House of Delegates here.

Central to the program, which will cost $45,000, is a plea for doctors to become shining examples of non smoking behavior and for doctors to encourage and help patients who want to quit smoking.

It is the strongest anti-smoking position taken by the AMA since it first addressed the problem in 1953 and banned tobacco advertising from its publications.

The AMA will urge the government to make stronger and clearer health warnings on cigarette packages and also on billboard advertising for cigarettes.

It will also encourage Congress to readjust the cigarette tax and hasten production of a safer tobacco.

The AMA emphasized the role of advertising in the sale of tobacco by adopting two resolutions aimed at curbing this effect.

One resolution charges the AMA to ask television networks to stop using athletes to promote tobacco products.

It also directs the AMA Auxiliary, along with support from Action for Children's Television (ACT) to help stop the promotion of cigarettes to children via TV.

The second resolution authorizes the AMA to praise popular magazines and newspapers that refuse to run ads for tobacco.

It is estimated 50% of the revenue for the most popular magazines kept in doctors' offices comes from tobacco advertising.

Other points covered by the new program relate to insurance premiums, Medicaid programs, and healthy lifestyles.

...and BMA hits tobacco advertising

LIVERPOOL — The British Medical Association has taken a strong stand against cigarette advertising, and has proposed increased facilities for treating alcoholism at its annual meeting here.

Delegates called for a total ban on cigarette advertising except at the point of sale; prohibition of candies resembling cigarettes; government legislation ensuring the tar and nicotine content of cigarettes is printed on packs; an increase in non smoking areas in public places and separate provision by health authorities for staff and patients who smoke; and higher prices for tobacco.

They supported these moves on the grounds that smoking was the greatest threat to health which was amenable to preventive measures.

Synthetic heroin tests Narcotic Act

VANCOUVER — A British Columbia Supreme Court judge has ruled that synthetic heroin is not a narcotic.

Justice Kenneth Fawcus accepted the argument of lawyer Mike Rhodes that the legal definition of heroin under the Narcotic Control Act is restricted to substances derived from the opium poppy, and excludes heroin made synthetically or derived from another organic source.

However, the ruling did not prevent the court from finding his client Patrick Douglas Lynds guilty of charges under the Act.

Mr Justice Fawcus accepted prosecution arguments that the economics of synthetic heroin make it unlikely street heroin is other than opium-derived.

However Mr Rhodes says the Crown gave no evidence how expensive synthetic heroin would be, and he plans to appeal Mr Lynds' trafficking conviction.

"As things stand now there are two kinds of heroin, one legal and one illegal," he told **The Journal**. The two kinds are, of course, chemically identical, except for possible differences in trace contaminants.

Will the underworld switch to synthetic heroin to exploit the loophole? Mr Rhodes says he doubts it.

For one thing the loophole can be easily closed. The schedule of narcotic drugs defined under the Act, last updated in 1962, could be reworded to include the words "heroin and similar synthetic preparations" as in the listing for cannabis.

"It's a matter of saying the emperor's got no clothing, and sooner or later the emperor is going to get some clothing."

GAMUT will link librarians

TORONTO — LISA, Librarians and Information Specialists in Addictions, is now publishing a newsletter.

Called GAMUT, the newsletter is intended "to provide a link for librarians, information specialists, and others interested in information service and delivery in the area of addictions," says Ron Hall, editor.

Mr Hall, head of information and promotion at the Addiction Research Foundation in Toronto, says GAMUT will be "informal and chatty in style" but will convey information on a variety of topics, and discussion of various issues.

"It should act as an alerting source; provide an opportunity for the sharing of information, ideas, and technology; and generally enable us to keep in better touch with each other."

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Jenny Cafiso, coordinator of the group, at (416) 595-6150.

Hassles and Hang-Ups

Number: 339.
Subject Heading: Attitudes and values, communication.
Details: 29 minutes, 16mm, color, sound.
Synopsis: Young people are subjected to many put downs and hassles from adults during the course of their growing up. Dr Garcia, and television personality Michael Douglas explore hassles that can lead to feelings of inadequacy which may, in turn, be associated with drug abuse. A mental health checklist is discussed; warning signs and possible intervention and treatment are identified.
General Evaluations: Good (4.0). An informative and technically well-produced film, which could be used as an effective teaching aid.
Recommended Use: Likely to benefit audiences of 12 years of age and older.

Everything You Always Wanted to Know About How To Stop Smokers But Were Afraid To Try

Number: 338.
Subject Heading: Smoking.
Details: Eight minutes, 16mm, color, sound.
Synopsis: With more and more non smokers aware of the dangers and inconvenience of cigarette smoke, one needs to be able to assert one's rights to request that a smoker put out a cigarette.
General Evaluation: Good (4.3). A contemporary and interesting film with a clear message, this film is of suitable length for most educational uses, and was deemed an effective teaching aid.
Recommended Use: Likely to benefit audiences of 12 years of age and older.

DEPARTMENT

New Books by RON HALL

Pot Smoking and Illegal Conduct: Understanding the Social World of University Students

. . . by Mohammed Nawaz

By obtaining primary data from more than 4,500 Canadian university students, and by means of systematic analyses, the author has identified some patterns of student socialization. Through participant observations, personal interviews, and anonymous questionnaires, the social world of university students has been explored and the meaning of illegal behavior to them has been interpreted. The findings indicate among other things that university students engage in illegal acts selectively and discriminately; they perform those acts that make sense to them and which fall within the daily course of events that comprise a major part of the university student culture. The data reveal that students' involvement is relatively high in "unserious" forms of illegal conduct. However, "serious" infractions such as assault, breaking and entering, or using or selling "hard" drugs violates prevailing cultural values, is detrimental to their student role on campus, and is incompatible with routine student activities.

(Diliton Publications, Inc, PO Box 1351, St Catherines, Ont, L2R 7J8. 1978. 224p.).

Addiction Research And Treatment: Converging Trends

. . . edited by Edward L. Gottheil, A. Thomas McLellan, Keith A. Druley, and Arthur I. Alterman

What are the contributions of basic and clinical research to treatment in the field of addiction? Can clinical settings and therapeutic observations provide the basis for valid research questions and designs? Can research and treatment of addiction take place simultaneously in coordinated programs? Questions such as these were the basis for the first annual Coatesville-Jefferson Conference on Addiction held in October, 1977. This volume presents selected papers from that conference to illustrate the mutual contribution of research and treatment in addiction. The first group of seven papers emphasizes the role of treatment as a resource for meaningful research, while the second group of seven papers revolves around the theme of effectively translating research into clinical practice and presenting emerging developments in addiction research. The final paper is a condensation of two panel discussions involving prominent researchers and clinicians in the field of addiction which focuses on the central theme of the conference.

(Pergamon Press, Inc, Maxwell House, Fairview Park, Elmsford, New York, 10523. 160p. $15.)

Drink Like A Lady, Cry Like A Man

. . . . by Jack Nero

This is the story of a man who watches his wife change from the "life of the party" to an unreasonable, depressed alcoholic. Her drinking becomes his number one problem and his attempts to help her include supervising her "cutting down", psychiatry and a hospital for the emotionally disturbed, and a "conrolled" vacation. This book emphasizes alcoholism as a family disease and includes information about the symptoms, language, and treatment of alcoholism, especially the workings of AA and A1-Anon groups.

(Compcare Publications, 2415 Annapolis Lane, Suite 140, Minneapolis, Mn, 55441. 1977. 293p. $6.95.)

Other Books

Doing Coke: An Ethnography of Cocaine Users and Sellers — Waldorf, Dan, et al. Drug Abuse Council, Washington, 1977. A study of 32 regular cocaine users from a white, middle-class background: reviews literature pertaining to effects of cocaine. References. 76p.

Recent Developments In Chemotherapy Of Narcotic Addiction — Benjamin Kissin, J. H. Lowinson and R. B. Millman (eds). Annals of the New York Academy of Sciences, Vol 311, 1978. Papers with references from a conference held Nov 3/4, 1977 in Washington, DC, sponsored by PACT/NADAP and the Academy. 315p. $42.

Alcohol Research In Norway — Hauge, R. National Institute for Alcohol Research, Oslo, 1978. Alcohol consumption and alcohol policy: alcohol research up to 1960: towards an institute for alcohol research: research outside the institute. Bibliography. 90p.

Come Closer Around The Fire: Using Tribal Legends, Myths, And Stories In Preventing Drug Abuse — National Institute on Drug Abuse. US Department of Health, Education and Welfare, Washington, 1978. A guide intended to show the value of the tribal stories in preventing drug abuse and to provide specific guidelines on how to use them. Bibliography. 32p.

Membrane Mechanisms of Drug Abuse — Sharp, Charles W., and Abood, Leo G. (Jt eds). Alan R. Liss, New York. Proceedings of a conference held at Silver Spring, Maryland, March 16-17, 1978. Drug receptors, constituents, and environment: drugs and neurotransmitter interactions with excitatory membranes: drug receptors — effects of interactions: drug effects on membrane fluidity, confirmation, and ion interaction: interpretation of drug effects through tissue culture systems. VII, references, indexes. 272p. $27.97.

Drug Use Among American High School Students 1975-77 — Johnston, L. D., Bachman, J. G., and O'Malley, P. M. National Institute on Drug Abuse, Rockville, 1977. Marijuana, inhalants, hallucinogens, cocaine, opiates, stimulants, sedatives, tranquilizers, alcohol, cigarettes. Attitudes, beliefs. References. Appendices include Questionnaire content and variable definitions. 237p.

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DEPARTMENT

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

17th Annual Scientific Assembly Of The College Of Family Physicians Of Canada — Ontario Chapter — Oct 14-17, Toronto, Ontario. Information: The Executive Secretary, Ontario Chapter, College of Family Physicians of Canada, 4000 Leslie Street, Willowdale, Ont, M2K 2R9.

Update '79 — Employee Assistance Or Occupational Health Programs — Oct 16-17, St Catharines, Ontario. Information: Mrs Karen Ferruccio, Addiction Research Foundation, 154 St James Street, St Catharines, Ont.

Dependeney: Threat or Challenge — Addiction Research Foundation and Psychiatric Nurses of Ontario — Oct 19, Toronto, Ontario. Information: Frank Fallon, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1. Telephone (416) 595-6083.

Detox Training Program — Oct 15-19, Nov 12-19, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell St, Toronto, Ont, M5S 2S1.

Public Showcase Al-Anon Meeting — Oct 18, Timothy Eaton Memorial Church, Toronto, Ontario. Information (Toronto area): Al-Anon, (416) 366-4072.

61st Annual Conference — New Dimensions in Children's Mental Health — Canadian Mental Health Association — Oct 25-27, Moncton, New Brunswick. Information: Canadian Mental Health Association, 2160 Yonge Street, Toronto, Ont, M4S 2Z3.

OAPSW 15th Anniversary Annual Conference — Nov 15-17, Geneva Park, Orillia, Ontario. Information: Ontario Association of Professional Social Workers, 696 Yonge St, Suite 501, Toronto, Ont, M4Y 2A7.

Clinical Orientation To Alcohol And Drug Dependence Seminar — Nov 19-23, Toronto, Ontario. Information: The Donwood Institute, 175 Brentcliffe Rd, Toronto, Ont, M4G 3Z1.

United States

31st Annual Scientific Assembly Of The American Academy Of Family Physicians (AAFP) — Oct 8-11, Atlanta, Georgia. Information: American Academy of Family Physicians, Communications Division, 1740 West 92nd Street, Kansas City, Missouri, 64114.

Evaluation Of The Alcoholic: Implications For Research, Theory And Treatment — Oct 12-13, Hartford, Connecticut. Information: Mrs M. Meadows, Alcohol Research Center, Dept of Psychiatry, University of Connecticut Health Center, Farmington, Ct. 06032.

Advancement In Alcoholism Symposium — Oct 14-15, Newport Beach, California. Information: Mr J. Fahey, Director, Advanced Health Systems, Inc, 881 Dover Dr, Suite 20, Newport Beach, California, 92663.

Substance Abuse And The Young Person Symposium — Oct 20-21, Niagara Falls, New York. Information: Dr Peter K. Gessner, Professor of Pharmacology and Therapeutics, State University of New York, Buffalo School of Medicine, 122 Farber Hall, Buffalo, NY, 14214.

The 2nd Annual Prevention Conference — Oct 22-24, Morristown, New Jersey. Information: Ms L. E. White, New Jersey Prevention Inc, PO Box 299, Pine Brook, NJ, 07058.

The 2nd Annual Regional Conference On Substance Abuse — Oct 24-25, Cincinnati, Ohio. Information: Ann Blankenhorn, Alcoholism Consultant, Central Community Health Board, 530 Maxwell Ave, Cincinnati, Oh, 45219.

Workshop On Effective Family Therapy With Drug Abusers — Oct 24-26, Philadelphia, Pennsylvania. Information: M. Duncan Stanton, PhD, Director, Addicts & Families Program, Philadelphia Child Guidance Clinic, 34th & Civic Center Blvd, Philadelphia, Pa, 19104.

Seminar On The Treatment Of The Drug And Alcohol Abusing Criminal And Delinquent — Oct 25 and Oct 31, Wheeling, West Virginia. Information: Donald L. Poffenberger, Director, Criminal Justice Department, Wheeling College, Wheeling, West Virginia, 26003.

Annual Meeting Of The Society Of Forensic Toxicologists — Oct 31-Nov 2, Williamsburg, Virginia. Information: Robert V. Blanke, Medical College of Virginia, MCV Station, Box 696, Richmond Virginia, 23298.

National Conferenee On The Problems And Preventions of PCP Abuse — Nov 3-4, San Francisco, California. Information: Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St, San Francisco, California, 94117.

4th Southeastern Conference On Alcohol And Drug Abuse — Dec 5-9, Atlanta, Georgia. Information: Dr C. Hunter Jr, Medical Director, Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd, Atlanta, Georgia, 30338.

Chemical Abuse And Mental Illness: Bridging The Gap — Dec 6-7, Leamington Hotel, Minneapolis, Minnesota. Information: Diane Campbell, Dept of Conferences, 315 Pillsbury Drive SE, University of Minnesota, Minneapolis, Mn, 55455.

Training Institute On Addictions — Dec 9-14, Miami Beach, Florida. Information: Training Institute on Addictions, c/o Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, Co, 80901.

Poisoning: A Symposium — Feb 11-15, 1980, Denver, Colorado. Information: Director of Professional Education, Rocky Mountain Poison Center, West Eighth and Cherokee, Denver, Co, 80204.

New Frontiers In Addictive Behaviors: A Conference Cruise To Alaska — June 14-21, 1980. Information: Merry Bush, Kawaguchi Travel Service, Alaska Cruise Program Committee, 711 Dexter Horton Building, Seattle, Washington, 98104.

Abroad

Experts' Conference And Workshop Of The German Central Office Against Addictions (DHS) — Oct 29-Nov 1, Fellbach, (near Stuttgart), West Germany. Information: Ms E. Göcke, Deutsche Haupstelle gegen die Suchtgefahren, Postfach 109, Bahnhofstrasse 2, 4700 Hamm 1, West Germany.

International Seminar On Community Involvement In The Prevention Of Drug Abuse — Oct 31-Nov 2, Jakarta, Indonesia. Information: Mr Soepomo Prono, c/o Bakolak Inpres 6/1971, Jalan Senopati 1/n° 51, Kebayoran Baru, Jakarta Selatan, Indonesia.

African Conference On Drug Abuse — A Multidisciplinary Approach — Nov 26-30, Lagos, Nigeria. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

1st Pan-Pacific Conference On Alcoholism And Drug Dependence — Feb 26-Mar 7, 1980, Canberra, Australia. Information: Pierre Stolz, AFADD, PO Box 477, Canberra City, ACT 2601, Australia.

National And Regional Workshop On Drug Abuse — Mar 10-15, 1980, New Delhi, India. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

26th International Institute On The Prevention & Treatment Of Alcoholism — June 9-14, 1980, Cardiff, UK. Information: ICCA, Case Postale 140, 1001 Lausanne, Switzerland.

10th International Institute On The Prevention & Treatment Of Drug Dependence — June 15-20, 1980, Cardiff, UK. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

5th World Conference On Therapeutic Communities — Aug 31-Sept 5, 1980, Noordwijker Hout, the Netherlands. Information: Mr Robert Chenevert, Monsterweg 29a, 223 RB- s Gravenhage.

33rd International Congress On Alcohol And Drug Dependence — 1981, San Jose, Costa Rica. Information: ICAA Case Postale 140, 1001 Lausanne, Switzerland.

Goodwin draws bead on some 'poppycock'

A sceptic's approach to alcohol

Harvey McConnell reports

WASHINGTON — Current interest in the fetal alcohol syndrome needs to be tempered with scepticism.

This is the conviction of Donald Goodwin, chairman of the department of psychiatry at the University of Kansas, and winner of several awards for his research into a possible genetic link for alcoholism.

Indeed, doctors and scientists should maintain a healthy scepticism about alcohol in general — whether about claims of the physical damage it may do or about methods of treating those who drink too much.

In an interview with **The Journal**, Dr Goodwin emphasized that he is not a cynic but doctors especially should realize "we don't know very much. And how could we expect to know very much given the small amount of money that has gone into alcohol research?

"In the absence of information, there is an inverse relationship between how much is known and how much poppycock is generated."

Fetal Alcohol Syndrome

Dr Goodwin says his experiences and observations in both research and treatment have led him to an axiom "which I would be happy for **The Journal** to promulgate first: if it is trivial you can probably study it. If it is important, you probably can't."

On fetal alcohol syndrome (FAS) he says about two years ago, he headed a committee which for two days listened to FAS researchers. The committee was to make recommendations for future research and produce a proclamation for the government on FAS.

There was complete agreement with the final draft which said, in essence, the animal evidence suggesting that alcohol is teratogenic looked convincing but human studies were still too preliminary to draw firm conclusions.

Dr Goodwin says: "We recommended that pregnant women be told of this, possibly by an FDA (Food and Drug Administration) notice that would go out to physicians informing them of the possible harmful effects on the fetus of alcohol consumption, but that it was not possible to say how much alcohol was required."

What was released eventually by NIAAA (National Institute on Alcohol Abuse and Alcoholism) "had absolutely no relationship to our recommendations.

"Not only was it said there is absolute evidence that alcohol consumed during pregnancy can produce fetal abnormalities, but it was also said that the safe level appears to be three ounces of absolute alcohol, but it didn't say over what period of time: an hour, a month, or a year."

Dr Goodwin says there is even disagreement among FAS researchers over their findings. He talked to one whose studies still indicate children of women who drink heavily tend to be smaller and have a small head circumference.

"However, what he does not find is any correlation between heavy drinking and the cranial and facial abnormalities, congenital heart conditions, and the cluster of features identified with FAS by other researchers. He said if there is a unique cluster, it takes a far sharper eye than he has to pick them out."

Dr Goodwin notes that in all the FAS studies "it is still difficult to find any in which the women who were heavy drinkers did not smoke cigarettes. The correlation between smoking and small birth weight is well establshed."

His own advice is to tell pregnant women not to drink, "although, actually, the most severe damage occurs before the woman realizes she is pregnant. So, really what we should be telling women is not to drink as long as they are of gestational age, and this is asking quite a bit."

Pitfalls in research

On research in general, Dr Goodwin points to pitfalls:

"As researchers, people have a natural investment in the studies they are doing. For example, I have found myself over time, and despite myself, coming to believe in a kind of hereditary factor in alcoholism.

"I didn't start out believing that. My prediction as a scientist was that, if anything, we would find non specific personality traits leading towards emotional instability, anti-social behavior, and the kind of nervous people who didn't fit in very well.

"We didn't find that at all. We found that alcoholism was transmitted and nothing else we could measure. Even then it was not a strong belief, but I tell you, the longer you stay in something, the more selective you get in the way you review evidence to fit your thinking.

"So now I think there are genetic factors involved, and there have been two other studies since ours which seem to bear this out."

A second danger for the researcher is to go overboard: "Zeal and enthusiasm can lead some people to think they have discovered something new under the sun. Unfortunately, some researchers are so convinced they have done this that they become very dogmatic."

On alcohol research in particular, he believes there is one factor which permeates it and which is not found in other fields. "This is the latent puritanism which still infects North American society. It pleasures us to see evil displayed: we sort of expect that anything which is going to give pleasure is going to give displeasure."

Evidence lacking

Turning to treatment of alcoholism, Dr Goodwin notes: "We really don't have a single study in the entire treatment literature that meets the acceptable scientific criteria for evidence — in other words, random assignment of matched patients to different treatment groups who are followed up sufficiently.

"So, when we talk about treatment for alcoholism, and while we go ahead and do it vigorously and enthusiastically, there is no scientific evidence that what we are doing makes a difference. I don't see why we should kid ourselves about it, although I don't see any point in telling patients that.

"Personally, I think what I do works almost all the time, but to be honest I don't have a controlled series. Randomization is an eternal problem."

It is the lack of any controlled series or random assignment that prompts Dr Goodwin to point out regarding AA (Alcoholics Anonymous) "there is no scientific evidence that it works.' Nevertheless, he believes in AA and sends as many patients as possible.

"There is no way this can be studied because you could not set up a random assignment trial. Proponents of AA would argue that you are dealing with people's lives and they know AA works because they see it work all the time.

"Yet I have data about people who don't go to AA, or who tried AA and didn't like it, who are still sober."

Dr Goodwin sees a danger in the constant repetition of "one drink and that's it." It may engender a sort of self-fulfilling prophecy "and once an alcoholic slips he thinks that's it and he might as well go all the way."

Dr Goodwin also takes issue with some claims made by the NIAAA.

NIAAA has said there are between 9.3 and 10 million alcoholics in the United States over the age of 18, and three million between the ages of 14 and 18.

Dr Goodwin says: "It is a totally fictitious figure. When the government got into the prevalence manufacturing business about 10 years ago, with the then modest National Centre for Alcohol Studies and its modest $5 million, we had five million alcoholics.

"Now we have more than doubled the number of alcoholics in 10 years during the time the government has been acting. I don't know where they got the 10 million."

Dr Goodwin feels "to maintain our credibility, I would discourage people from going around and saying there are 10 or 13 million alcoholics in the country. I think we better let it ride that there are plenty of alcoholics around."

NIAAA has also said the per capita consumption of alcohol in terms of grams of absolute alcohol is the highest since 1850.

Dr Goodwin: "This is fine. But one of the most thriving industries in this country until recent times was the moonshine industry, and they were not terribly cooperative in providing the government with figures as to how much they produced.

Alcohol/cancer claims

"So, nobody really knew how much alcohol was being consumed that was illicit. Now it is simply that more and more people are drinking alcohol and it gets on the records."

Dr Goodwin takes special issue with NIAAA's claim that "indisputably alcohol is a cause of cancer."

He says there have been three studies, for example, which linked heavy drinking with cancers of the head and neck. "However, one of the problems in dealing with cancers of the head and neck is that the number of heavy drinkers who are not also heavy smokers is infinitesimal."

A colleague of Dr Goodwin's at Kansas, Robert Rhodes, did a statistical study on one of the reports. "Dr Rhodes found that none of the data were statistically significant."

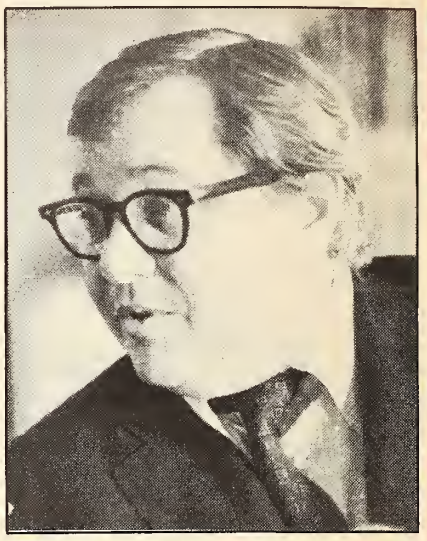
Dr Goodwin says his personal experience has taught him to beware of what appears a good thing at the time.

"A good while ago Flagyl seemed to be the upcoming thing to treat alcoholics. I was young then and wanted to do a double-blind trial, but a wiser and older head in my department suggested I first try it on some alcoholics. I gave it to a dozen alcoholics and it didn't help any of them."

He wrote a letter to a medical journal pointing out his experience and emphasizing that it was in no way a controlled trial. "I got a wire from them saying they wanted to publish the letter in the next issue, which shows that journals have a tendency to believe negative reports rather than positive ones.

"Meanwhile, we are still seeing controlled double blind trials of Flagyl come out from earnest investigators studying a drug which should not have been studied in the first place.

"This is a warning about drugs currently in vogue, or whatever comes down the pipe."



'If it is trivial you can probably study it. If it is important, you probably can't.'

'The correlation between smoking and small birth weight is well established.'

'... the most severe damage occurs before the woman realizes she is pregnant.'

'I think we better let it ride that there are plenty of alcoholics around.'

THE BACK PAGE

Canada pushed out of UN narcotics agency

By Jeff Carruthers

OTTAWA — For the first time in 33 years, Canada will no longer hold a seat on, and influence the direction of, the 30-member United Nations Commission on Narcotic Drugs.

Already, there is a pit-of-the-stomach fear among Canadian officials that the commission will soon return to the dark ages of international drug policy with emphasis once again placed on stricter police enforcement against drug users.

Thanks to a series of bungles by junior diplomats at the UN, Canada, Sweden, Austria, and the Netherlands found themselves out in the cold for two, possibly four years, starting in 1980.

The surprise failure of Canada to gain a voice and, therefore, a major continuing influence on how the commission coordinates international drug enforcement policies, came after the commission decided to abandon normal election procedures and, instead, vote members in on the basis of geographic blocs.

While the new approach provides more representation to developing countries, it carries with it the real risk of a dramatic shift backwards in the philosophy of the commission.

Canada, Sweden, and other western nations with a serious drug use problem, had been successful in recent years in promoting a philosophy of combatting drug use internationally that tried to get at the roots of the problem — looking both at areas of supply and reasons for demand for drugs, rather than just attacking the surface expression, ie drug use, through stricter enforcement measures.

Expressed simply, the Canadian and Swedish approach had been to use a carrot to reduce demand for illicit drugs; the earlier approach, which may well now return to the fore, is to use a stick in the form of international treaties and law enforcement.

Many of the developing countries on the commission routinely send law enforcement officials to the annual strategy sessions in Geneva for the war on drugs. And they bring with them a well-developed police mentality.

In Canada, officials are struggling to gain federal government approval for continued financial support for the commission.

Earlier this year, Canada slashed its contribution to the UN Fund for Drug Abuse Control, an arm of the commission, from the traditional $200,000 to $100,000. Continued fiscal restraint, combined with this latest setback, could reduce the contribution even further next year.

Under the change in election procedures, Canada found itself in the North American-Western Europe-Australasian bloc where drug abuse is a major problem and where nine countries were competing for six seats.

The Netherlands, Austria, and Canada were not elected and now are only observers with little direct influence. Sweden, also not elected, was in another bloc.

Canada's Dr Donald Smith, senior scientist in International Health Services, department of health and welfare, and this year's chairman of the commission, says there will be a lot of back room lobbying in the next couple of years in an attempt to get Canada and other allies back on the commission when the next election is held in two years.

See — Comment — page 6

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The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Pot, heroin put under Maori *tapu*

AUCKLAND, NZ — Calling on traditional means to fight drug addiction, Maori leaders have decided to impose a two-year *rahui* (ban) on illegal drugs.

The ban will be pronounced by an Anglican Maori bishop at a church service arranged by national Maori organizations and churches.

Drugs such as marijuana and heroin will then become *tapu* (taboo) and may not be touched. The rahui will apply to Maoris of any tribe, to their immediate families including spouses and in-laws, and to Maoris living overseas. It will be particularly publicized among Maoris living in Australia.

Now largely urbanized, Maoris make up 11% of New Zealand's population, and their involvement in drug abuse is disproportionately high.

In their traditional communities, the tapu system of prohibitions was one of the strongest forces of law. It covered such things as the person of a chief, a corpse, a new canoe, and a cultivated field.

Even in present times, Maoris widely respect the tapu that is placed on a stretch of water when a person drowns.

Immediate training urged for alcoholism workers

LONDON — The final report of the British government's Advisory Committee on Alcoholism claims that better education for medical, social work, and voluntary agency staff is crucial to improving services in the field of alcoholism.

It recommends that appropriate professional bodies examine the pre-qualification courses of doctors, nurses, and social workers to ensure they receive a basic education and training in the principles and practice of recognizing and helping problem drinkers.

UK alcoholism treatment in crisis —Page 5

Further, the committee suggests professional bodies should consider ways in which further education should be included in "post basic training."

Employing organizations should also consider providing appropriate in-service courses for staff, it recommends.

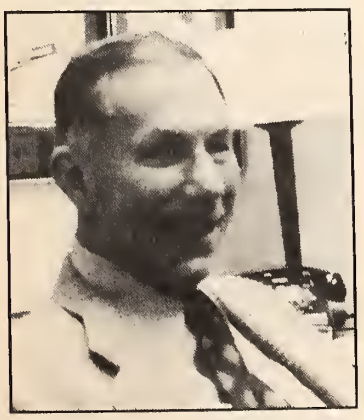
The committee urges the department of health and social security, other statutory authorities, and voluntary agencies to consider methods of meeting immediate needs for training of professional staff already in post.

It notes that on latest estimates, there may be a minimum of 500,000 people in England and Wales "with a serious drinking problem" and evidence suggests the problem is growing.

Senay coalition's first chairman

NADC unites US groups

CHICAGO — Edward Senay of Chicago has been elected chairperson of a new grouping of agencies in the United States — the National Alcohol and Drug Coalition-80 (NADC-80) and of the conference by the same name to be held in September, 1980, in Washington, DC.



Edward Senay: US drug agency separation has been costly.

It is the "broadest coalition" ever formed in the US in the alcohol and drug fields, Dr Senay told **The Journal.**

And NADC-80 should be "the best national meeting ever."

The coalition was formed at a September meeting in Washington, DC, of representatives from the National Drug Congress (NDC), the Alcohol and Drug Problems Association (ADPA), and the National Drug Abuse Conference (NDAC) (**The Journal**, Oct).

A nine-person governing board, with three representatives each from the ADPA, NDC, and NDAC, has been formed as an executive organ for the conference.

The new coalition represents "professionals, minorities, administrators, counsellors, and many other diverse elements in the drug and alcohol treatment systems," said Dr Senay.

He said an application for financial support has been made to the National Institute on Drug Abuse.

Dr Senay is executive director of Substance Abuse Services in Chicago.

The coalition is the result of leaders in the field trying to reconcile groups whose separation has been costly in a number of ways. Not least was the fact that after many months of feuding this year, the NDC, the NDAC, and the ADPA held meetings at separate locations but in the same week, the NDAC in New Orleans and the NDC and ADPA in Washington, DC.

INSIDE

Exclusive

SPECIAL SUPPLEMENT The Journal November 1, 1979 — Page 7

THE KENORA SYNDROME

'The thing that hurts the most is being invisible. White people see Indians walking in the street: they look at us, but they don't see us anymore...'

MARY SKEAD, RAT PORTAGE

By Jon Newton

Alcoholism and griefs observed

Kenora is a small town roughly 125 miles east of Winnipeg, and about 1,200 miles from Toronto as the jet flies. It has a population bouncing between 10,500 and 11,000.

Income derives mostly from the local pulp mill, tourists, and hunters and fishermen who flock to the area to take advantage of one of the few places left where wildlife has not been decimated by sportsmen. But its principal claim to fame is its "Indian problem." In the early 1960s, local Indians staged a march through the town in an attempt to focus attention on their difficulties. A decade-and-a-half later they organized the month-long occupation of Anicinabe Park, this time because they wanted the return of land rights — namely, this 14-acre parcel of land which they saw as being part of the nearby Rat Portage reserve.

One good thing — perhaps one of the few — to come out of either demonstration seems to have been the Kenora Street Patrol, an Indian-run project aimed at helping Kenora's native drunks.

Up-to-date statistics — accurate or otherwise — are hard to come by in Kenora. For example, staff at the local Lake of the Woods hospital keep records of Indians presenting with self-inflicted injuries, or attempted suicides. But when a local doctor tried to pull some of the latest together for The Journal, he was told the reports had been discontinued. No reason was given. Last year the police laid 2,832 charges for offences involving liquor. But how many of these pertained to Kenora's Indian population, tramlined or otherwise, or exactly in what they referred, were other questions.

However, four years ago, Indian Grand Treaty Council Three published a report which named alcohol as the main factor in nearly 90% of violent Indian deaths between 1970 and 1973. Sadly, in spite of its age, the report presents a picture which continues to be relevant.

It said alcoholism, sudden deaths, traumatic injuries, and crimes involving native people were prevalent and increasing, with young people and women coming to the fore. More than two thirds of the victims were under 40, and 22 were under 10 years old. Of the 189 cases studied in detail, most sudden deaths were accidental, chiefly by drowning. One hundred and forty two were "accidental." 24 were confirmed suicides, and 12 suspected suicides. Homicide was responsible for seven deaths, neglect for three. Gunshot wounds, stabbings, fire, and exposure, ranked high after deaths by drowning. Called *While People Sleep*, and prepared by the Centre for Settlement Studies, (University of Manitoba), the Kenora and District Planning Council, Treaty Three Itself, and The Concerned Citizens Committee, the report makes horrifying reading.

More than 200 Indian people in the Kenora area died violently in the three-and-a-half years preceding *While People Sleep*. At least half the victims had been drinking before their deaths and most were well over the 0.08% impairment level.

And unlike many similar reports prepared on underprivileged white communities, women were more likely to die than men.

"There are some differences between men and women in kind of death," stated the report. "Men are more likely to die by fire, drowning, and gunshot, etc; women by exposure and gunshot, stabbing, hanging, etc". The exceptions were not detailed.

Kenora, Shoal Lake, Grassy Narrows, Islington, and Red Lake were listed as the areas where sudden deaths were most likely to happen, with Kenora topping the roll with 31 sudden deaths between 1970 and June 1973. Next highest was Shoal Lake with 16 victims and Islington and Red Lake tied for third place with 11 deaths each.

In person-to-person trauma, Indian and white men were most likely to be injured, or to injure other men, a bile women were usually injured by men, especially their husbands.

Between Jan 1 and Dec 31, 1972, 100 men and 80 women were involved in "person-to-person contact trauma" with unintentional injuries amounting to 23 and 26, respectively, and a total of 22 self-inflicted injuries. But of the latter, 19 involved women.

More white than Indian women were hospitalized because of intentional self-inflicted injuries. But more Indian women had to be admitted because of injuries inflicted on them by other people. And the Indian women had to stay in hospital longer.

Kenora is unquestionably an embarrassed and ashamed town.

There is a seemingly endless list of societies and organizations each of whose raison d'etre is "to help." The fact these agencies frequently overlap, or are at odds with each other, is rarely mentioned. Liaison seems more a wish than a fact.

The Addiction Research Foundation office there does seem to have an excellent relationship with the Indians and with the community. But, as its "chief" Les Halverson, told *The Journal*: "Things aren't easy. There is still a very serious problem in Kenora, and although the picture is slowly changing and improving, it will be a long time before this town can look itself in the eye."

A TOWNSHIP RIPPED APART

Pages 7-14

Canadian cannabis convictions drop 15% — page 2

NEWS

Attack on traffickers cuts drug offences

By Jeff Carruthers

OTTAWA — Drug convictions in Canada in 1978 dropped significantly, almost certainly as a result of the switch in emphasis by law officials from strict enforcement of cannabis possession offences to a broader attack on drug trafficking and importing.

The latest drug statistics prepared by the federal Bureau of Dangerous Drugs reveal a 15% drop in total drug convictions from a total of 39,293 in 1977 to 33,256.

Cannabis convictions which still make up more than 95% of the total, dropped by 16% to 31,178; heroin convictions rose 7.2% to 402; cocaine convictions jumped 5.9% to 392; phenycyclidine (PCP) fell 18.9% to 500, and hydromorphone jumped 1,142.9% to 87 convictions. In terms of penalties, 55% involved fines, 7% involved probation and suspended sentences, 22.5% involved absolute or conditional discharges, and 12.6% involved jail sentences of one year or less.

By province, Ontario was the hotbed of activity with 38% of the convictions, followed by Alberta with 16%, British Columbia with 14%, and Quebec with 12%.

As usual, men far outnumbered women: 30,408 males were convicted compared to 2,848 females.

By age, the 18- to 20-year-old group ranked highest followed by closely by the 21- to 24-year-old; about half as numerous were the age groups on either side, that is those aged 25 to 29 years and those 15 to 17 years.

The 1978 heroin convictions, at 402 cases, remained well below the all-time high of 1,290 recorded in 1973 and the most recent low is the previous year at 375 cases.

By contrast, cannabis convictions seems to have peaked in 1977 at 37,812, and, in 1978, at 31,718, and are already below the 1976 of 33,281.

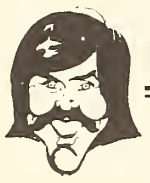
By province, cannabis convictions set the pace for drug statistics generally with Ontario the highest by far, followed by Alberta, BC, and Quebec; by crime, possession represented 87% of the cases, followed by possession for the purposes of trafficking at 7%, and trafficking at 5%. There were only 24 convictions under importing, and 156 for cultivating cannabis. For possession of cannabis, the sentences were mild; 83% were for fines, probation, suspended sentences, or discharges; another 3.6% were for jail of six months or less; and no sentence involved a jail term of more than two years.

By age group for possession convictions, 37% involved 18- to 20-year olds, 30% those 21 to 24 year, 14% those 25 to 29 years, 12% under 18, and 4%, 30 to 34.

The Bureau of Dangerous Drugs has obviously made some major changes in the way it keeps track of drug users in Canada. The emphasis is now on "known" drug users rather than suspected drug users. And, for the first time in recent years, there are no statistics published in 1978 on known cannabis users, who last year numbered an all-time high of 30,695, and who all had personal files held in the health department.

New users of illicit narcotic drugs in 1978 numbered 176 males and 54 females with most of them in BC and Alberta, most in their 20s, most involving heroin or cocaine, and most being reported by the police to the health department. The total number of known users of illicit drugs for 1978 was 18,389, with 600 under the age of 20; in 1977, the cumulative total had been 17,242 with an all-time high of 862 under the age of 20.

By Wayne Howell



Ballad for heroines of the RCMP

According to Ottawa lawyer Leonard Shore, the RCMP is now using attractive young females to entrap men into selling marijuana at rock concerts and bars. The RCMP has, of course, long used male operatives for the same purpose. But as Leonard Shore, who has seen two of his clients convicted of trafficking as a result of the new ploy, told the *Ottawa Citizen*: "They're not as effective as a pretty lady."

This poem is dedicated to those unsung heroines, the "pretty ladies" of the RCMP, who always get their man.

A passionate shepherd from afar
Was seated at a disco-bar
When he espied a maiden fair
With locks and locks of flowing hair:
A lovely nymph, from Heaven sent,
One look from her, his heart was rent,
And from his bosom there did flow
Pastoral verse from Chris Marlowe.
'Come live with me and be my love
And we will all the pleasures prove
That valleys, groves, hills, and fields,
Woods, or steepy mountain yields.'

But the maiden shook her golden head,
Unmoved by the verse he'd read,
So the ardent swain began anew
The lovely maiden fair to woo:
Perhaps he'd touch her heart's desire
If the verse soared even higher?
'And I will make thee beds of roses
And a thousand fragrant posies,
A cap of flowers, and a kirtle
Embroidered all with leaves of myrtle.'

But the lovely cadence of the verse
Did not affect her countenance
Because, you see, the law's own harlot
Owned a kirtle of mountie scarlet:
But of this the lad knew naught,
So he wooed again, still passion-fraught.
'A gown made of the finest wool
Which from my pretty lambs I'll pull;
Fair lined slippers for the cold,
With buckles of the purest gold.'

But the offer of the gilded shoes
Left the maiden's heart unmoved,
Because, you see, beneath her skirts
She wore a mountie's spurred boots:
But the shepherd lad knew nothing of this,
The love-struck swain found naught amiss,
So desperate now, with fevered brain
The passionate shepherd wooed again.
'Perchance a gift from Columbian fields
To me will make they pure heart yield?
An ounce or two of Heavenly Grass
To thee, with love, I humbly pass.'

The maiden turned and flashed a smile,
Loving, tender, without guile;
She clasped him to her tender breast,
And whispered to him: 'You're under arrest'.

(Wayne Howell is an Ottawa physician and freelance writer.)

Wrong combinations of heroin substitutes can be fatal.

Substitutes intensify heroin withdrawal

CHICAGO — Fatalities among heroin addicts who use as a cheap substitute for heroin the combination of pentazocine (Talwin) and tripelennamine (Pyribenzamine) result from using the wrong combination of these drugs, says a researcher.

(Talwin is a synthetic analgesic and Pyribenzamine is an antihistaminic.)

This results in fatal convulsive seizures and large drops in body temperature, says Hemedra N. Bhargava, associate professor of pharmacology, University of Illinois Medical Center here.

In experiments on morphine-dependent mice, Dr Bhargava found when both drugs were given in equal amounts, the intensity of morphine withdrawal was less than when only one of the drugs was administered.

But when the dosage was changed in either direction and more of one drug was given, withdrawal symptoms were intensified.

The most dangerous combination which produced toxic symptoms was found to be twice as much Pyribenzamine as Talwin.

Dr Bhargava disputes the contention that the drug combination helps an addict through heroin withdrawal by alleviating withdrawal symptoms.

"If anything it intensifies withdrawal," he told **The Journal**. The clue to why addicts use this potentially fatal combination came from observations of mice given high dosages of the drugs.

"We found that when large dosages of pentazocine and Pyribenzamine in either a two-to-one or one-to-one ratio were given, the mice lost coordination and had bizarre behavior patterns resembling the actions of a person experiencing hallucinations."

Dr Bhargava believes it is possible that the drug combination produces hallucinations or euphoria in humans.

"Under these conditions, drug withdrawal might not bother the addict," he concluded.

Now EAPs can criticize themselves

By Don Bastian

OTTAWA — There is a growing emphasis in the addictions field and the workplace on strengthening "both ends" of employee assistance programs (EAPs), according to Ken Bennett, program consultant, Central-West Region, Addiction Research Foundation of Ontario.

Reflecting on new trends observed at Input '79, the third biennial conference on occupational alcoholism and drug abuse here, of which he was chairperson, Mr Bennett said:

"Management, union representatives, and social workers were all asking for more stress on early detection of alcohol-related and drug-related work problems and, on the other end of things, for better means of follow-up for the person who has been helped in an EAP."

EAPs are coming to a level of maturity that is enabling them to become self-critical of weaknesses in their set-up, he said.

The three-day conference was opened by Madame Mary S. Lamontagne, a former president of the Canadian Foundation on Alcohol and Drug Dependencies, and a corporate director of the Banque Provinciale du Canada and the North American Life Assurance Company, among others.

Madame Lamontagne acknowledged the growing concern of corporations with drug-related problems, but reported confusion on the part of many chief executive officers as to how to handle them.

World of difference

And she criticized the lack of Canadian research on the "importance of the workplace in the health and general well-being of the worker."

"There is a world of difference between a Newfie and a Torontonian, not to mention between a Montrealer and an Inuit. But, oddly enough, they seem to have one point in common; they all insist, often vehemently, that they are not Americans," she said.

"It is therefore most unrealistic and highly unscientific to transpose studies done in the States to Canada and to extrapolate results. Yet, if my information is correct, this is exactly what we're doing."

Among presentations to all delegates was a report on the EAP experience of Canadian National Railways (CN) over the past 10 years.

The program began in one of the Railways' five regional centres with a concerned doctor and an employee involved with Alcoholics Anonymous,and spread to the other regions.

CN industrial health programs have handled more than 2,000 cases of employees with drinking problems, with a reported success rate of between 40% and 50%. (Success is measured as not having a relapse for at least a year.)

Translated into dollars, this success rate represents a gain of about $4.5 million annually in increased productivity for CN.

Donald Gregory Bastian reports:

EAPs neglecting women alcoholics

OTTAWA — The "typical" female alcoholic in Quebec has "a gut that's full" — from the stigma attached to being a drinking woman and her own feeling of guilt that she's not carrying out her duties at home.

But she has very few words to express it. With an average of nine years of education and the probability that once she admits her problem her husband will leave her, this woman is not being reached by treatment designed for the very different needs of male alcoholics.

This was the picture of the plight of the female alcoholic — particularly in the workplace — drawn by University of Montreal psychologist Louise Nadeau for Input '79, the third biennial conference on occupational alcoholism and drug abuse.

Ms Nadeau, who has worked in the Montreal therapeutic community Portage, is setting up a training program at the university for dealing with substance abuse. Last year she was a consultant in female alcoholism for the Ministry of Health in France.

Women who are alcoholics, she said, are caught in a web of harmful attitudes in society that threaten to deny their access to the help they need.

Ms Nadeau described some of the "Catch-22" situations women alcoholics find themselves in, which often limit the amount of help they can find.

Perfect and vulnerable

- Women are expected by men and families to be perfect, which boils down to their being expected to be able at all times to take care of the needs of others. Meanwhile, their own needs are not being met.

At the same time, women are supposed to be weak and vulnerable, in need of the protection of men.

As a result, their drinking problems cause them to feel a terrible guilt for having "fallen" from perfection. Because they are supposed to be perfect, fellow employees, managers, and even doctors will deny to themselves that women might have a drinking problem.

Furthermore, signs of emotion and weakness brought on by the problem will be dismissed as the innate vulnerability of women.

- When men come home from work, it is expected that they will have anger that needs releasing. But this is not always expected of women.

Depression is thus a greater hazard for women as they hold their anger within. "This is the perfect situation for developing alcoholism, because alcohol is used as a medication precisely for this state of feeling bad," Ms Nadeau said.

- In Quebec (and other provinces are similar), two-thirds of all psychotropic drugs prescribed are for women. "Doctors are trained in the psychoanalytic definition of women that sees their problems as mainly psychogenic," she said.

"Faced with a woman who needs to admit her drinking problem, he is likely to dismiss her by reaching for the prescription pad and prescribing her a tranquillizer."

Women who may be seeking help from doctors ironically are thus driven deeper into the problem of abuse — substance abuse.

- Finally, the woman who does seek treatment is too often forced to decide between treatment and taking care of her children. Without adequate daycare facilities, she cannot leave her family for detoxification or other in-depth treatment.

Women's unique needs

The traditional employee assistance program does not fit itself around this dilemma for women, she pointed out.

The fact male supervisors find women more difficult to confront than men about work performance, and that women don't socialize with fellow workers as much as men do, makes the drinking woman's camouflage all the more effective, Ms Nadeau said.

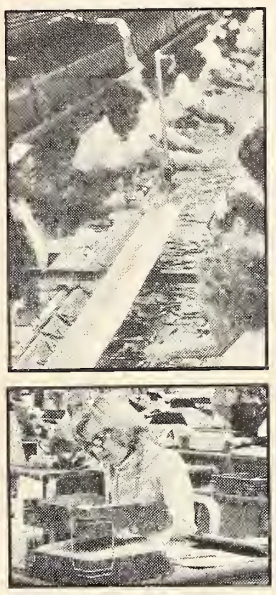
And while women may be more easily confronted about work performance by a woman, getting women more involved in occupational health programs will not necessarily help.

"Women's attitudes about each other also have to be changed. They also think that ladies don't drink, and the urge to deny the problem in other women is strong."

Calling for employee assistant programs that deal with the unique needs of women, Ms Nadeau said the first — and most crucial — step is to admit that women alcoholics do exist, and in growing numbers.

Once that is done, she said, programs must be developed that speak to women as women and that can give the promise of confidentiality.

"We need people who understand women's guilt and who treat the woman's problem in terms of how it's affecting the woman herself, and not primarily what it's doing to her children or husband."



'Traditional employee assistance programs in Canada — designed for the male alcoholic — are unable to cope with the unique problems presented by women.'

Are they too afraid to ask?

By Edith Robb

MONCTON, NB — Ten per cent of women seeking help from clinical psychologists in New Brunswick are suffering from alcohol problems, according to a survey just released by the provincial Alcoholism and Drug Dependency Commission.

The survey, by members of the New Brunswick Psychological Association, indicated that of the women admitting to drinking problems, most were under the age of 35; they were equally divided between those who work in the home and part time workers in the labor force; and all had fairly limited social and economic resources.

Janet Stoppard, assistant professor at the University of New Brunswick's department of psychology, Fredericton, and one of the psychologists who drew up the survey, said it was sent to approximately 120 psychologists. There was a 50% reply rate and about 40% of those said they treated women with drinking problems.

"And they were psychologists who worked in clinics or in psychological units at hospitals," Dr Stoppard said.

She said the survey indicated women were not going to the clinics just for drinking problems.

"They usually have other psychiatric problems, like depression or anxiety, or marital problems, and the drinking is part of it, or discovered because of those other problems.

"General literature on the problem of the female alcoholic often speaks of the middle-aged woman who drinks. Well, we didn't find her; our psychologists aren't seeing her."

She suggested these women and more working women were not revealed in the survey "because presumably they're going elsewhere with their problems, perhaps out of the province, or maybe they're not seeking help at all."

Many of the women treated, she said, expressed wariness of specific treatment for alcoholism or alcohol-related problems because of the social stigma.

"And many of them had a fear of being viewed as an unfit mother, as well."

The psychologists also concluded that most women with drinking problems in the province are not seeking help. And there is a general feeling among them, said Dr Stoppard, that there is an increase in problem drinking, particularly by younger women, although many may not have identified it as a problem yet.

Underworld shifts from heroin to pot, coke

By Harvey McConnell

NEW ORLEANS — Marijuana trafficking in the United States is now as extensive and as organized as any heroin trafficking the Drug Enforcement Administration (DEA) has had to deal with over the past decade.

Peter Bensinger, DEA director, said: "One of our major concerns is the criminal organizations dealing with marijuana. Those which made their money with heroin have switched to cocaine and marijuana because it is less risky, the penalties are far less, and the drugs are more readily available."

'One of our major concerns is the criminal organizations dealing with marijuana . . .'

Peter Bensinger

Mr Bensinger told the annual National Drug Abuse Conference here that the DEA and justice department are currently investigating assets worth $400 million which have been acquired through trafficking. New laws now allow seizure of any assets arising from narcotic trafficking.

The DEA's role is difficult because its resources allow only a selected number of investigations. "We have adopted a policy of not making the most arrests we can, not to go after everybody selling drugs, but to go after the major sources of supply."

This has reduced dramatically the supply of Mexican heroin, although now there is a growing threat of heroin arriving on the East Coast from the Middle East.

Mr Bensinger said one problem which does not get attention nationally, but is of great concern to his agency, is retail diversion of legal drugs — "doctors who set up no more than pill factories to make money.

"We have seen a tremendous number of abuse incidents, injuries, and fatalities, from pharmacies and doctors who are in business simply to make money. The number of overdose deaths from illicit diversion of legally produced drugs is three times as high as those from heroin in the US."

One doctor can be responsible for diversion of millions of dosage units. A pharmacist arrested in New York for drug diversion was found to have $1,200,000 in cash in his possession.

Mr Bensinger said several major investigations will be undertaken soon and decisions made on whether Congress should be asked next year for possible changes in the law dealing with retail diversion.

Mr Bensinger said there has been a marked increase in cooperation and exchange of intelligence among federal agencies. The DEA is now working closely with the US Customs Service where once there had been "a traditional battleground of who was going to get the case."

This cooperation and exchange of information has also been expanded internationally with foreign enforcement agencies, he said.

"Grinswald has the worst case of caffeine addiction I've ever seen."

NEWS AND COMMENT

US backs off alcohol issue: Bourne

WASHINGTON — Increased public interest in the problems of alcohol abuse, and increased demand for services, is reaching a peak at the same time the United States government has started to back off, believes former White House advisor Peter Bourne.

Dr Bourne said there has been a marked change in public attitudes. People see it more as a disease, as something that can be treated, and as "something people can recover from successfully."

At the same time, alcoholism having become more acceptable, the medical profession can accept it as a legitimate condition which should be treated.

Dr Bourne told physicians attending the annual conference here of the Alcohol and Drug Problems Association that while interest and demand for services is now there, the government has begun to back off in the same way it backed off from the drug issue.

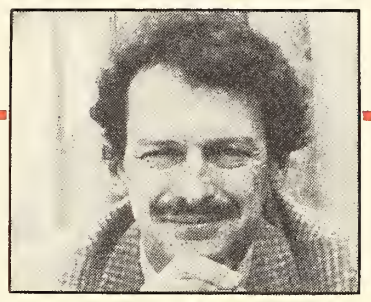
He explained: "Federal money began to be withdrawn as there was a feeling the crisis was not as acute as it was in the late 60s and early 70s. Now, it is almost impossible to get the kind of attention and commitment to increasing the federal drug budget that there was six or eight years ago.

"Similarly, I think there has been a spillover effect to alcoholism. There is a feeling this field is not as urgent as it was a while back and so the alcoholism budget similarly has been jeopardized."

There is now little hope of any form of national health insurance being adopted and, with it, provisions for treating substance abuse. "I think we have reached the point where the prospects of national health insurance are extremely remote at any time in the forseeable future," Dr Bourne added.

He said miscalculations had been made. "I think many of us made a mistake in being so preoccupied with seeing alcohol and drug abuse treatment within the framework of national health insurance. We devoted so much time and effort to this approach, which we thought was going to be inevitable, that we ignored other strategies and other areas where I think we should have been devoting a lot more time and effort.

"What has always struck me here in Washington is that there was a mistaken belief that if you really wanted to get some changes, as far as provision of services, you really needed to bring all your people here to Washington. In fact, you could accomplish a lot more in taking people to state capitals and lobbying state legislators."



GILBERT

'North America's most extensive advertising ban . . . may have had the effect of increasing the amount of smoking.'

A case for tobacco advertising

By Richard Gilbert

First I should declare my bias: I dislike much advertising intensely. I dislike the way it interrupts TV shows and clutters up newspapers. I resent its influence over my children and its reinforcement of people's greed. Above all, I abhor the scary cynicism of some of the people who devise advertisements.

Having said all that I'm going to argue that recent moves to ban tobacco and alcohol advertising, may be wrong-headed. They include resolutions by the World Health Organization, by the British Medical Association, and, more locally, by Toronto's Board of Health.

Banning ads on buses

The Toronto resolution led to a conditional ban on tobacco advertising in and on vehicles and property administered by the Toronto Transit Commission (TTC) from May 1, 1980 — perhaps the first of its kind in North America. The condition is that somebody comes up with a way of finding the $200,000 annual revenue that would be lost.

The main reason given for the TTC ad ban was that it would help reduce tobacco use. No evidence was presented for this assertion beyond a statement by a former advertising executive who professed being amused by the suggestion that "advertising, a function which has been shown to increase consumption of every other product, somehow miraculously fails to work for tobacco products."

One of the many groups supporting the ban was the Consumers Association of Canada (CAC), acting according to a policy against tobacco advertising adopted in 1973. Yet, in February this year, CAC argued something else with respect to alcohol advertising — that " . . . well-done counter-advertising is more effective as an anti-drinking measure than bans on promotion."

Evidence

That quote was taken from CAC's comments on a 1978 study by Jaques Bourgeois and James Barnes of Carleton University. These investigators asked: "Does advertising increase alcohol consumption?" Their literature review covered tobacco and alcohol products and concluded "there exists no conclusive evidence that the total amount of advertising by the companies in a particular industry has any significant effect on the aggregate demand for the products of that industry . . . advertising generally can be shown to have an effect on particular brands." Their research showed that there is "little evidence to support the claim that the level of per capita consumption of beverage alcohol in Canada is influenced by the volume of advertising for the products concerned."

The United States Surgeon-General's 1979 report *Smoking and Health* made no specific recommendations about advertising. It did raise the possibility that North America's most extensive advertising ban — of cigarettes on US television and radio from 1970 onwards — may have had the effect of *increasing* the amount of smoking. From 1967 onwards US broadcasters had been required to provide free time, on request, to groups that would match tobacco advertising with anti-smoking messages. This free time was being used extensively by 1970. The noticeable decline in per capita cigarette consumption was, some believe, a result.

When cigarette ads were banned at the end of 1970, anti-smoking ads all but disappeared too, because the source of their funding disappeared: they no longer qualified for free time. Per capita cigarette consumption in the US started to go up again. Whereas it had fallen from 4,120 to 3,930 between 1967 and 1970, when there were both pro- and anti-smoking ads, it rose from 3,930 to 4,010 between 1970 and 1973, when there were neither — perhaps a classic case of throwing the baby out with the bath water.

New Smokers

Banning cigarette advertising may have a specific effect on young people who are beginning smoking that cannot be detected when the whole population is considered. Data in the Surgeon-General's report bear this out. The proportion of US teenagers smoking at least once a week rose by some 30% between 1968 and 1970, when both kinds of ad were permitted, and fell slightly between 1970 and 1972 when ads were banned. The changes were particularly evident among 12- to 14-year-olds. Moreover, the proportion of teenage smokers consuming 10 or more a day remained constant from 1968 to 1970 but increased substantially after the ban was imposed, adding further weight to an argument that advertising cigarettes influenced initial recruitment to smoking and that negative advertising had more influence on the regular smoker.

Paradoxically, there is other material covered in the Surgeon-General's report that suggests a greater potential influence of anti-smoking ads among young people. The report noted that "cigarette ads are perceived by teenagers as hypocritical and are listed as 'least-liked' while anti-smoking ads are perceived as 'straight-forward' and are liked." I think that the problem with the US anti-smoking ads in the late 1960s may have been that they were directed at adult regular smokers, not teenage new smokers. Teenage smoking might have declined if the ads had been telling teenagers that if they started smoking, they would probably smoke until they died.

Censorship

The evidence, such as it is, points to a conclusion that we should both ban tobacco advertising and provide for anti-smoking ads. There are two problems here. One is finding the means to pay for the anti-smoking ads. This need not be a problem if tobacco ads are allowed. They can be surcharged to cover the cost. The other is more fundamental. It has to do with the kind of society we want to have. I don't want a society that readily resorts to censorship. As long as tobacco is a legally permitted substance, I think it would be just as wrong to allow advertising *against* its use without allowing advertising *for* its use as it is to have the latter and not the former. Only in exceptional circumstances should we censor out one side of an argument. If the matter of tobacco use is so exceptional, we should be thinking about banning or restricting the product, not the words and images that describe it.

Surcharge

For me, then, it is a question of whether to argue for no advertising, either for or against tobacco, or to argue for both kinds of advertising — which means ensuring adequate funding of anti-smoking ads. Notwithstanding the US experience that having both kinds together may have deterred regular smokers but not new smokers, I would argue for maintaining cigarette advertising but applying a surcharge to provide funds for anti-smoking groups to advertise. There should be two provisions. One is that advertisements for cigarettes not be directed at young people — a difficult matter to enforce but one that needs some attention. The other is that much of the anti-smoking advertising be directed at new and likely new smokers — another difficult matter that could also do with a lot of attention.

As far as the TTC is concerned, I suggest that the commission reconsider its ban (which may not happen anyway because of the escape clause about revenue) and consider instead a surcharge on tobacco ads, directing the proceeds to agencies that would produce anti-smoking ads. Travelling by TTC would be more interesting.

Next month: Lowering the legal blood alcohol limit.

Coffee habit may promote addiction —to alcohol

By Jean McCann

ACAPULCO — There's increasing evidence caffeine may promote alcoholism . . at least a lot of caffeine.

That's the word to coffee-drinking members of AA (Alcoholics Anonymous) and others, from a researcher addressing the Third World Congress of the International Commission for the Prevention of Alcoholism and Drug Dependency here.

Patricia Mutch, a nutritionist from Andrews University, Berien Springs, Mich, said: "We gave animals a controlled diet adequate in all nutrients, and then compared them to another group on the same diet, but to which we gave caffeine to the equivalent of nine cups of coffee a day, on a body weight basis.

"The animals were then offered a choice either of a sweet alcohol or a sweetened sugar solution, and the animals who received the caffeine drank significantly more alcohol during the four week period of time than did the animals who were receiving no caffeine."

Dr Mutch said the reason animals — or people — reach for the alcohol could be that the coffee induces tremulousness, and the alcohol calms this down.

There are probably also biochemical reasons, she said. Alcoholism has been associated with higher than normal levels of serotonin, a brain neurotransmitter, which gives a "reved-up' feeling. Thus a person may drink the alcohol to lower his serotonin levels, and become calmer.

"The serotonin theory doesn't explain all of it. There's another biochemical theory that goes along with it, and that's the addiction part.

"This is that the person has breakdown products of alcohol which interact with dopamine, and that neurotransmitter, plus the breakdown product, acetaldehyde, combine to form a morphine-like compound in the brain, which is addictive . . ."

Alan Massam reports

Gloomy future looms for UK alcohol field

LONDON — In the face of a likely government cut-back in support for alcoholism treatment and rehabilitation programs, it now seems certain the whole field here is facing its biggest crisis for years.

This is spelled out in a recent report from the British Federation of Alcoholic Rehabilitation Establishments (FARE) which takes an extremely gloomy view of the future.

The report says: "While central and local government are haggling about 'who is responsible' the ever-increasing numbers of those seeking help will be deprived of the service they need.

"This is a very serious situation and there are fears, fully justified by other recent government decisions in this field (like the winding up of the Advisory Committee on Alcoholism) that support now given to local services will either be reduced or withdrawn next year.

"Not only is planning for the future quite impossible for the management committees of non statutory projects when faced with such uncertainty, but ultimately, given the continuing rapid increase in alcohol problems, the country as a whole must suffer."

The report adds that although the government has made an effort to improve health education on the effects of alcohol, "there are at least 500,000 people for whom the initiative has come too late."

"They, and those who are daily being added to their number, need help — which in too many places is simply not available."

The FARE report results from the setting up of a working party at the House of Commons last year, jointly chaired by a former Labour MP Helene Hayman and a Conservative MP, Sir George Young, now undersecretary of state for health in the present government.

Government 'too often retreated into idealism'

It is, perhaps, a telling comment on the 'responsibilities' of power, that the title page of the document carries a footnote which stresses that since Sir George assumed office during the preparation of the report, "he cannot be committed in advance to its recommendations."

In fact, the working party found that the British government had "too often retreated into idealism and been indecisive" when faced with the problem of alcoholism. Moreover, agencies providing a service "had been too complacent in the face of such an unsatisfactory response and slow in taking initiatives to improve the situation."

The essential questions were:

1) Does the country need an alcoholism service?

2) What are the required components of such a service?

3) Should facilities be paid for out of local funds, or should the government provide permanent support?

4) Are non statutory organizations to be part of a national strategy to deal with alcoholism — and, if so, are they to have equal access to resources?

The working party state that they have taken into account the winding up of the Advisory Committee on Alcoholism and the related winding up of the Sub-Group on Homeless Alcoholics and "come to share the exasperation of those who have waited so long for the implementation of the 1971 Home Office Working Party on Habitual Drunken Offenders recommendations" (namely that prison is not the best place for them).

Further, after looking at uncertainties about detox centres, the working party wondered whether the government had, at times, been serious about implementing its own policy.

"The frustration and anger which has become evident among many alcoholism workers, in both statutory and non statutory settings, as a result of often unilateral and apparently uncoordinated policy decisions at the highest level, and an unwillingness of officials to listen to their experience, has led us to the conclusion that if such skill and dedication is to be retained and built upon, then urgent action is required — and it is required now."

Among the report's principal recommendations are:

1) That all concerned should have "a more explicit understanding" of the part which must be played locally in the provision of services for alcoholics;

2) That the government at its Department of Health and Social Security must be ultimately responsible for the provision of a national alcoholism service, providing back up financial assistance where necessary;

3) That there should be an increased determination on the part of the Goverernment to take alcohol problems out of the penal system.

The FARE indictment of government services and attitudes to the alcohol problem was almost immediately endorsed by an independent report issued by the London Council on Alcoholism (LCA) which stressed the capital was doing even worse than other areas in terms of service provision.

● *Community Services for Alcoholics, Federation of Alcoholic Rehabilitation Establishments, 3, Grosvenor Crescent, London SW1 (Tel 01 235 0609) Price £2.*

'US workers abroad need drug counselling'

Stress — including political stress — caused by the stark realities of overseas employment is prompting alcohol and drug abuse in many American families. Here, earlier this year, anxious Americans wait at Teheran airport in hope of leaving strife-torn Iran. (See The Back Page).

By Harvey McConnell

WASHINGTON — A "multi-national mental health system" is urgently needed to cope with the pill popping and excessive drinking of Americans and their families working abroad for large corporations.

This is the major conclusion reached following a two-year study in Europe and the Middle East of employees and their families by Dale Masi. The study was done for the 16 corporation-member International Occupational Program Association. Dr Masi, of Boston College, is currently director of the Office of Employer Community Services for the department of health, education and welfare.

Her study found employees are lured by high salaries offered for overseas posts, but are often not fully informed of the stark realities in some areas, and they, and their families, end up trapped in situations which lead to severe alcohol and drug problems.

Overseas personnel directors, in turn, are unprepared for the results. Many told her stories "of attempted suicides and having stomachs pumped, of getting teenagers out of jail on heroin charges, and trying to deal with alcoholic employees with no treatment resources available."

Dr Masi, in her report to the annual conference of the Alcohol and Drug Problems Association/National Drug Abuse Congress said: "What is needed is a multi-national mental health system which must give comprehensive coverage to include mental health, drugs, and alcohol. If one had to set priorities, wives and children are experiencing even more emotional stress and emotional illness than employees themselves."

Dr Masi found "many women are so depressed they stay in their homes for weeks at a time and never get dressed. Wives, children, and teenagers are experiencing pressures due to radical changes in life caused by living outside the United States. The problems are especially evident to those assigned to the Middle East."

Dr Masi called the situation a vicious circle. Personnel directors in the US must fulfill contract requirements and "literally find bodies to staff the projects." Screening is haphazard.

Personnel directors abroad "are faced with working with people who do not know what to expect and often are disappointed and unhappy. The pressure is on the personnel directors to help retain these employees as it is a reflection on them if the employees leave before contracts are terminated."

'Healthy' alcoholics easier to treat

HAMILTON — Alcoholics are getting onto the band wagon of personal responsibility for health, and it's making them easier to treat.

George Blake, director of psychological services at Oshawa General Hospital, and formerly director of its Pinewood Centre for alcoholism, spoke of changing attitudes at the annual Institute on Addiction Studies here.

"We have seen attitudes change from regarding alcoholism as a moral issue, associated with crime and with being bad, to a disease model, and back to the moral issue in disguise . . . Responsibility for one's health and one's behavior implies personal standards.

"Those of us who work in clinics are finding it easier and easier to get the alcoholic to respond to treatment," Dr Blake said. "Certainly our techniques have improved, but also there have been changes in societal attitudes towards alcoholism — employee assistance programs for example — to remove the stigma.

"But most importantly, individuals are finding it easier to make personal decisions about their alcoholism . . . The alcoholic is part of a trend . . . people are participating more in health producing activities."

Self-imposed health risks, including alcoholism, now account for more deaths, hospitalization, and sickness than all viral and bacterial conditions, he said, and the health care delivery system is making individuals more accountable for their well-being.

The medical message is no longer, 'You're ill, I'll treat you' but, 'What are you doing to stress yourself'. A measure of how up-to-date your doctor is in his thinking is whether he asks about drinking, smoking, and other aspects of lifestyle, Dr Blake said.

A drink nips coronaries?

ACAPULCO — Alcoholism is responsible for congestive heart failure or heart irregularities in perhaps 5% of heavy drinkers, according to Richard Bing, honorary president of the International Society for Heart Research and professor of medicine at the University of Southern California.

However, Dr Bing said the question is still not settled as to whether a small, rather than a large amount, of alcohol may be beneficial in terms of preventing heart attacks by raising the "good" HDL cholesterol in the blood.

"I think from the clinical point of view it is important to resolve this argument", Dr Bing told The Journal during the Third World Congress of the International Commission for the Prevention of Alcoholism and Drug Dependency here.

Dr Bing said new epidemiologic studies are needed also. Current studies cite conflicting opinions as to whether a small amount of drinking is beneficial, or detrimental, in terms of coronary artery disease.

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A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Canada loses seat on narcotics commission

Will UN focus shift back to enforcement?

Anne MacLennan comments

Canada, for the first time in decades, will not have a seat next year on the United Nations Commission for Narcotic Drugs. This is more than simply a blow to Canadian pride (See page 1).

At best, it will inhibit the gradual move of the commission over the last decade to a more balanced and humane approach to combatting world drug problems. At worst, it may leave a gap through which the commission can slip back to the days, not so long ago, when law enforcement was all.

This is so because Canada, with Sweden, which has also lost its seat on the commission, has been instrumental in pushing and shoving that body slowly into an awareness that law enforcement directed at drug supply isn't ever, on its own, going to end world drug problems. This country has made it clear that the problem of world demand for drugs — the fact people want them — must have equal time and attention. There must be balance.

People who attend the Geneva meetings each year still talk about

The most influence

the "old days" either with resentment that they're passing or with fear that they aren't yet sufficiently bolted in the past.

Those days peaked in the 1960s when, often led by the United States, which had, and has, the most money, the most influence, and the most glaring drug problems, the commission's favored approach was brute force. Get the producers, get the traffickers, and we'll clear the world — or the US at least — of drug problems.

In the past decade, two things gradually happened. The enforcement message filtered through to developing countries and, again gradually, got translated into action. In areas where it was often impossible to keep surveillance, officials nevertheless beefed up law enforcement.

Now, commission officials from developing countries are among the most hard-headed in their approach, measuring up, in terms of intensity, to the standards called for seven or eight years ago by developed countries.

At the same time, the US, with changed leadership, slowly modified its approach both to enforcement and to drugs. Reports of liberalization of cannabis laws throughout the West, but again particularly in the US, have horrified and shocked many in the developing world.

As Thomas Land reported (**The Journal**, Oct) major Asian countries producing the illicit drugs flooding the black markets of Europe and North America, have now warned the West against undermining their efforts to control production. In a behind-closed-doors meeting held by the UN International Narcotics Control Board in Geneva, 17 Asian countries took a joint stance against

Half-hearted reforms

half-hearted Western law reforms and called the current trend in Western Europe and North America to more liberal cannabis laws "an active encouragement to expanding illicit production as well as smuggling and related crimes in other parts of the world."

Throughout this time, Canada, Sweden, and others (including Mexico and Pakistan) continued their attempts to make the richer countries understand that getting rid of the producers and traffickers (in the poorer countries) must go *in tandem with* attempts to reduce demand for drugs — licit and illicit.

The importance of Canada's role in this and the esteem in which it is held was reflected in 1978 in the appointment of Donald Smith, chief of Canada's delegation and the commission's then vice-chairman, to head an international study intended to be the operational blueprint for future action in the field. Dr Smith is senior scientist, International Health Services, Health and Welfare, Canada.

The study was in response to the first-ever substantial resolution related to drugs to come from the UN General Assembly in New York. The aim was to review the problem as seen by each country — rich and poor — in terms of individual approaches to treatment, and rehabilitation and prevention, and to review the needs each country saw itself as having in order to cope.

A chief emphasis in the report, which has now been presented to and applauded by the commission, was on the need to reduce demand.

In his report to the commission last year, Paul Reuter, president of the International Narcotics Board Control Board also emphasized the need now for attention to demand:

Three strategies, nationally and internationally, must be pursued — control of illicit traffic, eradication of illegal supply, and *the checking and reducing of demand*, he said.

The question of demand reduction has a hold on the commission. Canada was instrumental in achieving it and should be there to help maintain it. But, the push from many representatives, some still flushed with beginners' enthusiasm, remains on the side of enforcement.

Without Canada, without Sweden, the bolt that holds the "old days" more or less in the past, stands at risk of being at least loosened and possibly undone.

EDITOR'S NOTES

The Journal is pleased to draw attention to the new name on our masthead — Oriana Josseau Kalant, consultant. Dr Kalant is particularly known for her extensive reviews of the scientific literature on amphetamines, cocaine, and, currently, cannabis. The addition of her name is formal recognition of the working relationship between The Journal and Dr Kalant established over the past year. She contributes regularly both in terms of material for publication and of regular discussions on the merits of published or proposed articles. Dr Kalant, a scientist, is head of the documentation unit, Addiction Research Foundation of Ontario.

* * *

Readers may notice a slight change in our appearance this month. With this issue, we've moved to a new typeface called Imperial, on all articles. We believe it's both more legible than our previous typeface, Royal, and more flexible in terms of design.

* * *

Special in our December issue will be a Poster/Calendar for 1980 prepared by our popular editorial cartoonist, Yardley Jones.

* * *

Letters to the Editor appear on page 15.

THE KENORA SYNDROME

'The thing that hurts the most is being invisible. White people see Indians walking in the street; they look at us, but they don't see us anymore...'

MARY SKEAD, RAT PORTAGE

By Jon Newton

Alcoholism and griefs observed

Kenora is a small town roughly 125 miles east of Winnipeg, and about 1,300 miles from Toronto as the jet flies. It has a population bouncing between 10,500 and 11,000.

Income derives mostly from the local pulp mill, tourists, and hunters and fishermen who flock to the area to take advantage of one of the few places left where wildlife has not been decimated by sportsmen. But its principal claim to fame is its "Indian problem." In the early 1960s, local Indians staged a march through the town in an attempt to focus attention on their difficulties. A decade-and-a-half later they organized the month-long occupation of Anicinabe Park, this time because they wanted the return of land rights — namely, this 14-acre parcel of land which they saw as being part of the nearby Rat Portage reserve.

One good thing — perhaps one of the few — to come out of either demonstration seems to have been the Kenora Street Patrol, an Indian-run project aimed at helping Kenora's native drunks.

Up-to-date statistics — accurate or otherwise — are hard to come by in Kenora. For example, staff at the local Lake of the Woods hospital kept records of Indians presenting with self-inflicted injuries, or attempted suicides. But when a local doctor tried to pull some of the latest together for The Journal, he was told the reports had been discontinued. No reason was given. Last year the police laid 2,032 charges for offences involving liquor. But how many of these pertained to Kenora's Indian population, transient or otherwise, or exactly to what they referred, were other questions.

However, four years ago, Indian Grand Treaty Council Three published a report which named alcohol as the main factor in nearly 70% of violent Indian deaths between 1970 and 1973. Sadly, in spite of its age, the report presents a picture which continues to be relevant.

It said alcoholism, sudden deaths, traumatic injuries, and crimes involving native people were prevalent and increasing, with young people and women coming to the fore. More than two-thirds of the victims were under 40, and 22 were under 10 years old. Of the 189 cases studied in detail, most sudden deaths were accidental, chiefly by drowning. One hundred and forty two were "accidental," 24 were confirmed suicides, and 12 suspected suicides. Homicide was responsible for seven deaths, neglect for three. Gunshot wounds, stabbings, fire, and exposure, ranked high after deaths by drowning. Called *While People Sleep*, and prepared by the Centre for Settlement Studies, (University of Manitoba), the Kenora and District Planning Council, Treaty Three itself, and The Concerned Citizens Committee, the report makes horrifying reading.

More than 200 Indian people in the Kenora area died violently in the three-and-a-half years preceding *While People Sleep*. At least half the victims had been drinking before their deaths and most were well over the 0.08% impairment level.

And unlike many similar reports prepared on underprivileged white communities, women were more likely to die than men.

"There are some differences between men and women in kind of death," stated the report. "Men are more likely to die by fire, drowning, and gunshot, etc; women by exposure and gunshot, stabbing, hanging, etc". The etceteras were not detailed.

Kenora, Shoal Lake, Grassy Narrows, Islington, and Red Lake were listed as the areas where sudden deaths were most likely to happen, with Kenora topping the roll with 31 sudden deaths between 1970 and June 1973. Next highest was Shoal Lake with 16 victims and Islington and Red Lake tied for third place with 11 deaths each.

In person-to-person trauma, Indian and white men were most likely to be injured, or to injure other men, while women were usually injured by men, especially their husbands.

Between Jan 1 and Dec 31, 1972, 100 men and 88 women were involved in "person-to-person contact trauma" with unintentional injuries amounting to 23 and 26, respectively, and a total of 22 self-inflicted injuries. But of the latter, 19 involved women.

More white than Indian women were hospitalized because of intentional self-inflicted injuries. But more Indian women had to be admitted because of injuries inflicted on them by other people. And the Indian women had to stay in hospital longer.

Kenora is unquestionably an embarrassed and ashamed town.

There is a seemingly endless list of societies and organizations each of whose raison d'etre is "to help." The fact these agencies frequently overlap, or are at odds with each other, is rarely mentioned. Liaison seems more a wish than a fact.

The Addiction Research Foundation office there does seem to have an excellent relationship with the Indians and with the community. But, as its "chief" Len Hakenson, told *The Journal*: "Things aren't easy. There is still a very serious problem in Kenora, and although the picture is slowly changing and improving, it will be a long time before this town can look itself in the eye."

A TOWNSHIP RIPPED APART ⟶

A TOWNSHIP RIPPED APART

White man figure whoever somewhere 'fore him don't count. He call dem savages.

--Alex Haley in Roots

Kenora has everything. The countryside is breathtakingly beautiful. Its lakes and rivers run with huge wall-eyed pike, bass, and other game fish. Moose, deer, and bear draw hunters from all over North America during the season. In fact, few places can match it — particularly when the leaves change color in the autumn.

But turn the page and see a community withered by prejudices. A township ripped apart, pilloried by the media. Degraded. Ashamed.

The superlatives fit.

For though Kenora is hardly more than a pin-point on the map, it represents a scenario enacted all over North America with white men, Indians, and alcohol as the main ingredients.

I'm from England and, until last month, the nearest I got to an Indian was in the cinema. However, even an ocean away, I had heard of Kenora. The streets were littered with drunken, fighting Redskins and townspeople couldn't step outside their front doors at night because of the violence.

And there was something about mercury pollution poisoning the water. Kenora.

There are two ways to get there. By jet to Thunder Bay or Dryden, and then a flight to the town's tiny airstrip in a twin-engined Otter. Or, travel by newsprint. Either way, the situation is difficult to believe.

My two objectives were an interview with George Councillor, the Ojibway medicine man appointed as native spiritual advisor to the local Lake of the Woods District Hospital, and an article on Kenora — from the Indians' perspective.

George's new job was made possible earlier in the year by a $26,400 grant from Ontario's Ministry of Health, and included acting as a kind of linkman between the hospital's Indian and white populations.

On his appointment, George told one reporter his medicine wasn't meant for white men's diseases like cancer or ulcers. "But there are Indian sicknesses that doctors can't see, like when a bad medicine man puts a curse on somebody. White men call them emotional problems and hallucinations.

"In our culture, you can get sick from many things. If you hurt a small animal or a bird you might have problems many years later. It's forbidden by the Great Spirit to be cruel. You have to fit in with the way things work."

It didn't sound a bad way to look at life. But, tragically, George drowned in a boating accident the Saturday before I arrived.

And his death — he was an expert woodsman and fisherman — cast a pall over what had been an exciting prospect, an experiment which may have proved to skeptics that given support and understanding, Indian leaders *can* use traditional methods and help their people.

But Kenora's Indians, Ojibways all, are superstitious. Many of the older people saw the tragedy as a warning — don't go into the white man's world with our medicine. The spirits don't like it.

I couldn't speak with George, but I could, I hoped, meet other Indian leaders in an attempt to discover how the story looked from their side of the fence.

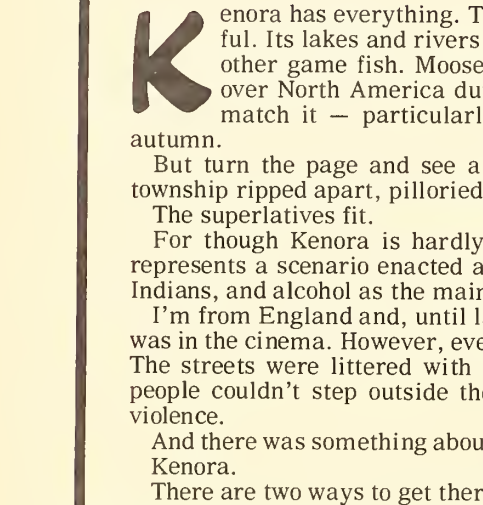
They showed me. In spades.

Monday I set up interviews, found a hotel, walked Kenora to get the feel of the town, and drew up a plan of action.

Tuesday, I filed the plan in the garbage bin.

I couldn't believe Kenora.

Meeting people was no problem, thanks largely to Len Hakenson, ARF's director in Kenora; Andy White, chief of the Whitefish Bay reserve, one of the district's most progressive settlements; and to Robin Greene, grand chief of Treaty Three, an association comprising 25 chiefs representing 8,000 Indians in an area covering a staggering 55,000 square miles.



And thanks also to people like Alec Skead, an ex-chief who now runs Kenora's Indian street patrol; Bill Jack, one of the patrol's first members; and his partner Mary Skead.

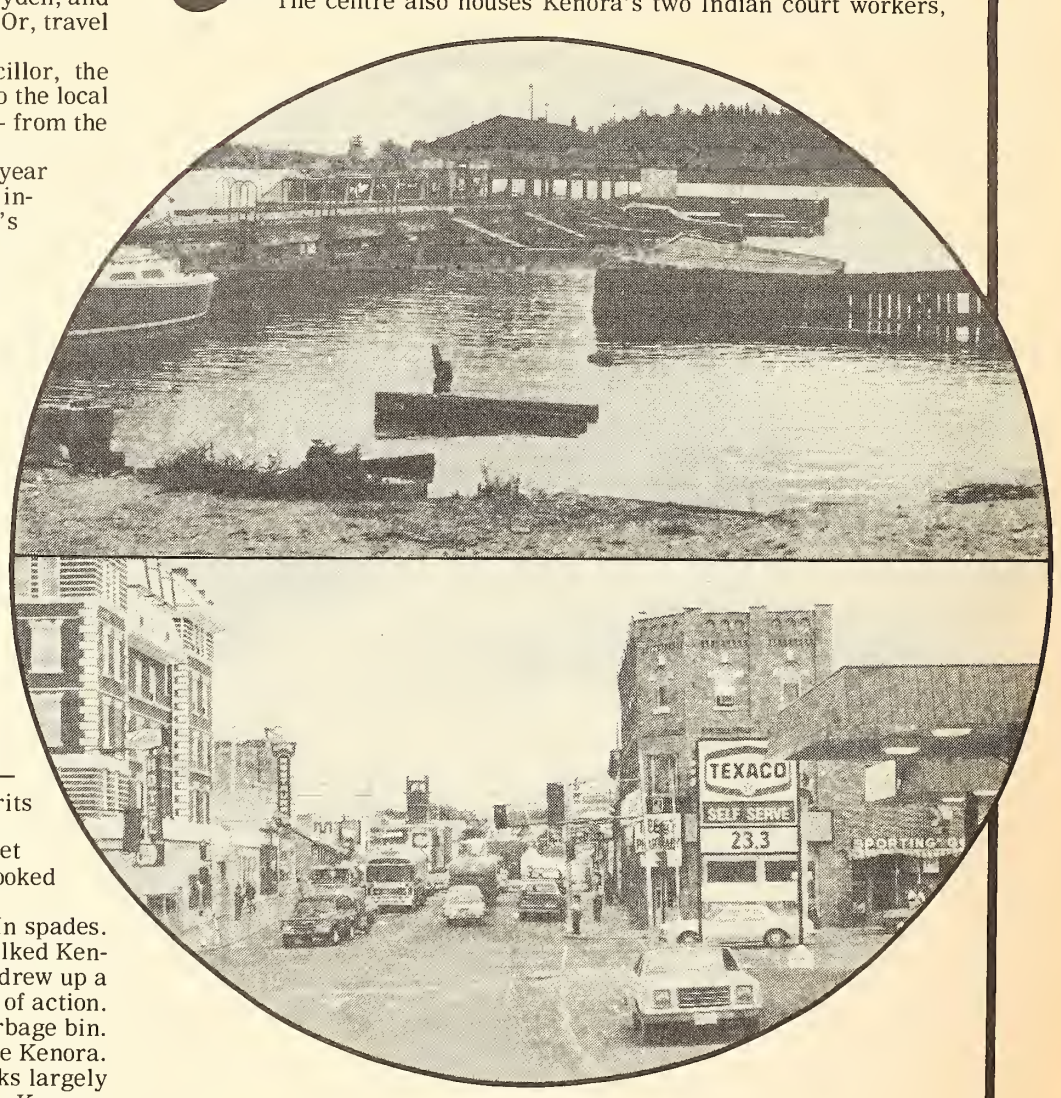
They arranged for me to go with the patrol that night, and spent a lot of time and patience answering questions which must, to them, have often seemed both ignorant and fatuous.

Three-and-a-half days were all I had, barely time to scratch the surface. But it was enough to leave me wondering how this community could continue to live, day in, day out, with the situation.

I made no attempt to speak with local businessmen, church leaders, the heads of the many different associations which exist to help the Indians, or to Kenora's whites. I spoke mainly to Indians and two or three white people who work closely with them.

Just after dark on Tuesday, I met Mary and Bill in the Ne-Chee centre on Kenora's Second Street. Some of the younger Ojibways go there to listen to records, to talk, and generally to stay out of trouble.

The centre also houses Kenora's two Indian court workers,



Unlike Kenora's many white drunks, Indians do not have a room to hide in while they're drinking.

and is the three-year-old street patrol's headquarters.

For a while we sat and chatted. For, in spite of Len Hakenson's efforts to clear the way, there was still an almost palpable air of distrust and suspicion emanating from Mary and Bill.

Not that they were unfriendly, but the "town" Indians and the different reserves — with their populations — have already been researched to death at one time or another, with little to show from the Indians' point of view.

Naturally Bill and Mary wondered what I was doing there, and if yet another tale of the Indians' depredations and wickedness would emerge. They had good reason to be suspicious, but were prepared to try.

Mary and Bill have worked together as partners in the street patrol since it was started after the occupation of Anicinabe Square. Before that they were drinking partners. For, like every Indian I spoke to, chiefs included, both have been the full route themselves. They know what it is to collapse in the gutter after a gut-full of cheap wine or beer. They know what it's like to wake up in jail, wondering what happened the night before.

As I climbed into one of the street patrol's special jackets before setting out for the evening, I was nervous. If they had their doubts about me, I also had a few about them.

Mary, at 44, is the mother of eight children, all of whom have gone through, or are going through, drink and/or drug problems. She was suffering the loss of her common law husband, Tom, who 10 days earlier had started out on yet another bender, leaving her to look after the six children at home — no running water or inside toilet — on Rat Portage Reserve, two or three miles from the town centre.

Mary had been dry since the previous autumn. She had been sober for five years before that but, like so many, fell off the wagon.

She told me she was born in nearby Wabagoon, moved to Kenora where she lived in the town itself, went on to Texas for a spell, and then returned to Pat Portage — a reserve proper — for the first time.

In that time, she has been through the mill; she has seen her children in and out of jail for offences ranging from being drunk and disorderly, to sniffing glue, to causing grievous bodily harm. And she herself has been in and out of trouble the whole while.

She has also seen her two "legal" husbands die — one burned to death after drinking too much; the other committed suicide.

Bill Jack, stony-faced, had little to say. Later I realized he never was very talkative — but now and again he dropped a dry comment which let me know he was aware of his position in the scheme of things. Nowhere.

I was to spend a long seven hours with these two — representatives of a group which was, according to many of the press reports I had read earlier, guilty of making the town of Kenora a hell-hole.

In fact, both were intelligent, dignified, human beings who were, and are, surviving existences which would have the average non Indian in Kenora, or anywhere else in Canada for that matter, screaming about injustice.

Our first Indian drunk was looking for a hand-out to get back to his reserve. Or so he said. I thought it more likely he would walk any loose change straight into the nearest bar or liquor store.

He said he had already blown what little cash he had on booze, and was now afraid of being beaten up if he tried to get back by thumbing a lift.

Later, I saw that Indian drinkers don't usually lie when they ask for hand-outs. They say they intend to use the money for alcohol. Our man really did want to get home. He was drunk and admitted it without shame. He also admitted, without shame, that he was frightened.

We carried on walking, looking at places where Kenora's floating Indian population are forced to bed down for the night. Like a cardboard box wedged between the garbage bins in a back alley. Like a filthy mattress in a ditch. Like the planking beneath a dock.

These "habitations" are used summer and winter — and winter in Kenora can mean 40°F below zero. It's hardly surprising Indians die from exposure when summer fades.

Because unlike Kenora's many white drunks — a phenomenon rarely discussed — the natives do not have a room to hide in while they're drinking. They have to whack the booze back as quickly as they can, being unable, for the most part, to take it to the reserves.

Back in town centre we headed to the Lake of the Woods Inn on Second Street.

An old Indian woman, about 65 and drunk as a lord, was propped against an automobile. Her face was badly battered and swollen, and one of her knees was cut. She was covered in blood and dirt.

The street patrol called a taxi, took her to the detox unit — next to the ARF centre, but funded by the hospital — and on to the hospital about two miles away.

The staff had seen it all before — a drunken Indian who had fallen flat from too much booze. She was checked over, cleaned up, and back at detox within 30 minutes. Not for her a night on a ward for further examination.

The staff were sympathetic, but they see similar cases in emergency every day of the week, and their apparent indifference was hardly surprising.

Without the street patrol, it's doubtful anyone would have bothered with the old lady. She would have collapsed — or recovered — on her own.

The attitude of at least some whites to such an event? "It's the Indians'fault, anyway. We give them enough money, but they just spend it on booze. And they're all drunkards, even the kids. We have a nice town, but the Indians ruin it, in spite of all we do to help."

By now it was about 2 am, and I left Mary and Bill to continue their patrol, to help more of their people to the detox or the hospital before they ran foul of a street gang, or were more badly affected by exposure.

Over the next two days, I talked to people — to Andy White and Robin Greene and Mary Skead — and to staff at the ARF (Addiction Research Foundation), among others. Everyone was determined to stress the positive. The street patrol was responsible for preventing a lot of deaths, for example. Or, the whites were making more determined efforts to try to understand *why* things were the way they were. They were struggling to understand the Indians' philosophy of life and how it affected their drinking. Some were also at pains to point out that lots of government money was being deployed to assist the Indians.

I found a recent article in **The Journal** (Oct) instructive in this respect. In it, Manfred Jager reported on work by Angus Reid, a professor of social and preventive medicine at University of Manitoba medical

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About the supplement

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Kenora could have a future, if people—Indians and whites both—made a determined effort to bury their differences.

(from page 9)
school. Dr Reid, wrote Jager, had found evidence that Canadian provinces spend half as much money on the treatment of Indian alcoholics as they do on white alcoholics. Dr Reid also found that the average level of funding in 1976 for 367 drug and alcohol agencies with programs catering primarily to whites stood at about $155,000. Programs designed for Indians had average annual budgets of only $77,000.

"If we don't provide appropriate service to the native alcoholic, we're looking at health and social problems on a scale that most whites would be very upset to have to live with in their community," said Dr Reid.

Kenora certainly is a town with a problem. But the Indians I spoke with were, without exception, intelligent, determined somehow to help themselves and each other, dignified, and articulate within the context of their own society.

They were not angry or bitter towards the townspeople, nor were they drunks.

Situations filled with tension do occur, especially when the media make one of their periodic fact-finding visits.

For instance, I was told about one TV crew which paid an Indian $20 to go into a restaurant, order a meal, and then say he could not pay for it. Quite naturally, the proprietor blew his stack and called the police. This "incident" was later presented as being typical of the sort of thing which goes on in Kenora.

Perhaps years ago there was an excuse for inter-racial tension. But no longer.

What seems to have been created is a snow-ball effect.

So much national and international attention has been directed at this small township that it is suffering from virtual mass schizophrenia.

Surely there is a sufficiency of research material available in the archives to give workers data from which to draw conclusions. Meanwhile, there are areas virtually untapped which might benefit the Indians — ie what part does the Fetal Alcohol Syndrome play in the troubles experienced by the younger generation of Indians?

The economics of the situation could also stand closer study. Local industry can in no way cope with the needs of the Indians, even if it were prepared to hire them.

So seasonal jobs, like picking blueberries and wild rice, have to satisfy a large bulk of the Indian population. Part-time work, like laboring for the construction industry or in local agriculture, is scarce and the only steady income for a lot of families is through public assistance.

Not much trapping goes on nowadays, and the call for Indian guides has also dropped. One of the principal reasons is the mercury-contamination scare, but the fact is this once important source of income is drying up fast.

But Kenora could have a future, if townspeople — Indians and white both — made a determined effort to bury their differences.

The town is smack in the middle of some of the most beautiful countryside in Canada. Given the chance — and some intelligent guidance — the Indians are capable of working out their own salvation. They don't have to be tourist deterrents.

They are guides whose expertise does not have to be confined to hunting and fishing. There are plenty of photography buffs about, who would leap at the chance of being taken to remote areas to capture what's left of the wildlife in its natural setting.

At the moment traditional handicrafts are practised by only a handful and although Kenora has a native women's craft shop, not much is done to promote the work.

One complaint expressed by the Indians is they want to return to the old ways, and to instruct the younger generation in their forefathers' lifestyles.

Perhaps a full-scale, authentic Indian village could be developed. This would give both Indians and whites an opportunity to research the good old days and ways, and would give the young the possibility of direct involvement in recreating their fast-vanishing culture — an industry geared to the needs of the Indians, but also providing Kenora's townspeople with a means of collaborating if they so wish.

Maybe it's also time for the researchers to pull out and for people like me to take a holiday and give the townsfolk and Indians — *not* the officials — a chance to take a long, hard look at what has happened, and is still happening.

Because I'd bet my right arm that if this *were* to happen, and people — Indians included — were to put past prejudices behind them, where they belong, everyone — Indians and whites both — would have not just a town whose scenic beauties would be the envy of any area, they might also learn they have a community which could set the pace for similar townships in other parts of Canada.

Through no particular fault of its own, Kenora has been dragged into the public eye. Perhaps now it should take a chance to show what can be done through the application of simple common sense, and a desire to work together■

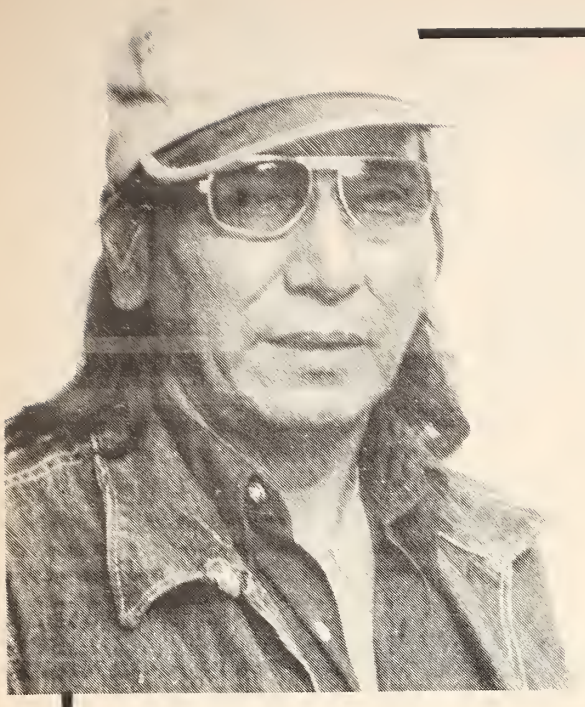
The scene looks normal enough . . . a family photo of Mary Skead, her 19-year-old son Patrick (far left), son Lawrence (16), and daughter Stella (17), at home on Rat Portage Reserve. But, Pat has had trouble with alcohol and drugs and is facing a possible two years in jail on an assault charge. When we last spoke, he said he was determined to put the past behind him. With help, he could do it.

Stella had her first drink at the age of 12 and also stands a chance of becoming another of the town's statistics. Like Pat, she is intelligent and bright and has as much potential as most other young Canadians her age. Whether she'll get the opportunities she needs remains a question.

Lawrence has seen his brothers and sisters "go through the mill" and he too says he's determined — not even to start going in the same direction. He wants to go to college and use his knowledge to help his people■

VIEWPOINT/ ROBIN GREENE

We are not angry



Robin Greene is grand chief of Treaty Three, a powerful association looking after the interests of 8,000 Indians — represented by their 25 chiefs — occupying an area of 55,000 square miles. Its offices are in the Cultural Centre.

The sheer vastness of the area creates problems: many people in this huge tract have only limited access to the bigger communities, roads are often poor or non existent, and some groups are virtually cut off from "civilization."

As grand chief, Robin coordinates the activities of Treaty Three and acts as its figurehead. This year, he was one of the chiefs who went to England to petition Her Majesty, Queen Elizabeth, on the subject of an Indian constitution.

He also travels widely in North America in an attempt to resolve, at least partially, the problems which are plaguing his people.

"Alcohol abuse is certainly our main problem. It's responsible for most, if not all, our troubles and we know we have to get to grips with it before we can really make a dent in our other difficulties.

But if we want to do the job right, we need a budget that will let us provide resources and staff to the bands. And this is something we do not have.

We know who's out on the reserves — the people who have, to some extent, conquered their drinking problems — and we know we could rely on them to help us with other Indians suffering from severe drinking difficulties. But, unfortunately, we don't have enough money available to reach them.

However, if we *were* able to get to these potential advisers and counsellors, we would start to get a little feedback from the groups in the more isolated areas.

The primary purpose would be to establish better communications because, in the six months I have been grand chief, I have found communications between the reserves and the resource outlets in Kenora, do not work properly. After all, Kenora is the point central to these various reserves — that's why our office was sited here — but it is not much use if the people we are trying to help don't have access to us.

I know from my own experience — luckily I've managed to keep dry for 10 years — just how serious this problem of alcohol abuse is. My own family, for instance, tend to take the avenue I took when I was young, even though they see I no longer drink. And this is why I wonder at times about other ways we can resolve this. Somehow, we have to get the drinking down. Statistics on Indian people are frightening, and we know we have to motivate the people so they can begin to take an interest in what's happening to them. This is very important.

Somehow we have to let the people know what's been happening to them, and that there is help. We have to put the people who want to do something for themselves in touch with each other, and and eventually help others.

The other thing I have found, particularly in Kenora — and it makes things very difficult for native people here — is the situation which exists in Kenora itself.

When one of my own people joins Alcoholics Anonymous (AA), two or three years later he is back where he was. It's the white people who do this and the man wants to drink again. They like to see us where we are now, with an alcohol problem. That's why it's so big here. I think the white people are quite conscious of this and really, they want things to stay the way they are.

But you can't run away from alcohol. You have to look it in the eye, and many times AA teaches you to run away from it.

"We are not angry, or bitter, or resentful about what has happened to us. We can't change it now. But I think there is a very basic difference between us.

Your people have known alcohol for centuries. Mine have not. I have always said, and I'll say it again to the government and to the people who are really concerned about the Indian people . . . when you hear in Kenora about discrimination, it's there and it's always been there. The people higher up in the town deny it. But it is here. All they are doing is making words for the media, and trying to make things easier for themselves. But as an Indian who has tried to find work will tell you, it is there.

Before this place became the cultural centre, I went to school here when I was seven. I stayed here all the time and never went home. The only time I saw my home was when school was out. So you could say this is where I was brought up.

I know this changed me considerably. On the reserve, we ate what was there, like wild animals . . . moose, deer, bear, rabbits, and these sort of things. Now, some of those things I used to eat, and used to love, taste differently to me because I have been exposed too long to things like beef and the foods the white society live on. My body has adapted itself to their ways. Also, I know my body — even my blood — has gone their way.

I certainly don't feel right about any of it. I know I was better off where I was, and the white people were better off too. But I couldn't say I feel angry about this. There was nothing I could do about it. But I'm sorry I have adapted to these ways as much as I have. I know it is required if we are to get by in this world that we find ourselves in.

I was told of the old ways by my father, and I grew up with them for a little while. Our younger people often don't have this to help them.

I was also told about our religion. God is everywhere, in everything. He is in the trees, in the water, in the sky, in the plants and animals. He is in the earth. And through this we knew about certain things we could do, and other things we should leave alone. We had respect for everything around us, and the wild animals.

My son is now 25 and has spent most of his time in school. Only two years ago, though, he started to realize what had happened. He was in his second year at university. He said, now I'm in my 20s, maybe I'd better lay off the school for a while because I think I've absorbed enough to get by. He's an artist and he doesn't need some things. I accepted this. It was his decision. In my heart, I felt really good about it.

This is my son's third year at home and he is still adjusting in many ways. There were many things he didn't know. Like about survival and the Indian way of life. And in a way this relates to the high rate of drop-outs among Indian students in the Kenora area. And you cannot blame them. They come into Kenora for an education — but all they learn are the ways of the white society. But when the warm weather starts, they lose interest. It is to be expected. They are Indians. And although they don't know why, they are feeling like Indians. Somehow their hearts are with the old ways, and they want to go back to them.

But the people in Kenora see these drop-outs as a failure. They don't understand that what is happening could be good for us. Really, it is not failure, but success.

There must be a way that our two peoples can get together and share the things they have in common, and learn from the things which are different. There is room for that. It is a matter of getting the right people together so they can talk and negotiate.

There are 25 bands in this area, and they are all different. They are not all the same, as many white people think. One area will think about doing something the others would not have thought of, and this is passed on.

Some bands are very advanced; others are still very far behind. But they are all learning, and many are beginning to look towards a real Indian government. Many know it is better for them to administer their own affairs.

"It would also be nice to see people using their Indian names. The names we have now were given to us by white people so they could put us on paper. But one way Indians can get their identities back is to use their Indian names. They are special — a symbol in our lives; the names carry us through eternity. This is the purpose of the names. There is no question that those of us who have Indian names cherish them. To me, I am proud of my name, which translates to something like the Moving Thunderbird, Circling Thunderbird. Ma-jee-biness. Some people get three or four names through their lives. The reason behind this is every time he is really sick, or a big thing happens in his life, an elder or a medicine man comes and gives him another name, which is the start of his new life. These are things we know. We know the white man's expression 'to turn a new leaf.'

The professional people like doctors and politicians have to realize this fundamental difference between our two cultures. We can work and live together, but people must know about and be aware of these differences, which can be quite big in many areas.

I don't think they pay enough attention to this. We thought we had begun to find a way through George Councillor. But he drowned (**The Journal**, Oct). He was very respected by Indians throughout the whole of Ontario, and was one of the few people in our society who was dedicated to his people.

Our people are very superstitious and I've heard some say: 'This is what happens when you try to work in white society.' But I don't believe that. My own personal opinion is we have to find someone like George and continue what he began. We must face it and live with it. There will always be people in both societies who will harass people like George. It will take a little time now, but someone else will come forward. Indian people know it is good.

For the future, if we can keep on getting the little successes and build them into big ones, I see self-government by our own people for themselves. This would mean living on our own land under our own control. And I think one day it will happen.

They would not be giving us land because it was ours to begin with. They would be returning it. If we found resources on the land we would use them to exist. The whole idea behind our government would be to get our share of what has already been taken from us. The white society tends to believe we want it all back. But we're not asking for this. What we want is an equal share, nothing more. But we want to remain Indians. We want our heritage and our identity. Is there something wrong in this?"

When The Journal visited Kenora, Robin Greene was Grand Chief of Treaty Three. He did not stand for re-election for personal reasons. Andy White took his place and is now president of the council.

VIEWPOINT/ALEC SKEAD

It's hard to live like this

Alec Skead has been responsible for Kenora's Indian Street Patrol, funded by the Ontario government, since it started operating on an official basis three years ago.

Until recently, its four members have worked mainly during the summer day-light hours, and at night during the winter. Last month they began to operate round-the-clock. Two members on days, and the other two on nights, switching rotas regularly.

Many of Kenora's white inhabitants see the patrol as having one function — to keep Indian drunks off the streets and out of their hair. But it has far more importance than that. It saves lives. For until it was introduced (a similar patrol, financed by the federal government operated for about six months in 1973 but had to close shop) the bums — male and female — and derelicts were often left lying in gutters to die of injuries received during bouts of drunkenness, or from simple exposure: in winter, temperatures often drop to -40°F.

Its officers walk the streets in the distinctive Kenora Street Patrol jackets, armed with vouchers to pay local taxi drivers when they need to transport someone to the Lake of the Woods Hospital, and with flashlights to search out the nooks and crannies where drunks hide in the night. Although they also try to head fellow Indians away from potential trouble, sadly, most of the time all they can do is make sure they get to hospital, or the detox unit.

Alec became supervisor after spending a lot of time as a patrol member. A chief for six years, he is well-known and respected and has a realisitic attitude to his difficult job.

"Our patrol have all been through this drink problem themselves. They've experienced it and they know all the people and all the places. Also, they do a little counselling as they go along. Our aim is to try to help, and to show examples.

Before the patrol we had deaths and accidents. But since we've been operating we've been able to save some of these people. What we do now is to take them to detox, and what happens from there depends on them a lot. But at least they've been saved for that night.

Sometimes gangs of white youngsters, drunk or on drugs, insult or hurt the people. But since the patrols, it's dropped off a lot.

What still happens, though, is when someone wants to go back to the reserve: you never know when you're going to be attacked. It's a gang of young fellows that goes around. They're probably all doped up too, sniffing gas, or glue, or whatever.

As I see it, everyone is a human being and everyone has a right to live the way he wants. As Indians, we can't live the way we want. We have a foot in the reserve and a foot in the town. It's hard to live like this. I have a lot of ideas, but I don't know what the real answer is. At the bottom, though, we must always try to help people.

I'm sure many people in Kenora — the white people — have seen trouble for so long that they don't notice what goes on around them any more. They can walk past an Indian, look right at him, and they don't see him. They can look at people lying in the gutter, or queuing at the liquor store, and they don't see them.

I'm 58 now and when I was a kid there was hardly any alcohol about. The reserves were dry then. The strong belief of the Indian people is in nature. This is the way my father taught me. He said our God is nature — the country — and I believe this is the truth.

They have to respect every living thing in this world. And human beings have to respect one another. This is what my father used to say. Anything that grows, that's your medicine. God is in the water, in the lake. He's in everything, everywhere, and that's what the Indian believes. Anything they do is in prayer. When they used to make birch bark canoes they took the bark from the tree, but left it standing. They took it at a certain time early in the morning. All these things were sacred, and in those days they didn't need police. This was your invention. And these were your police. By respecting the good things in the world, we lived. If you start making wrong rules and making fun of these things, or the person who believes in them, or anything crippled, you have a punishment right there — and this is what the young people used to be afraid of.

But although I believed, I still had problems with alcohol. I was a drunk. This is what I say. When you start using alcohol, you respect nothing. You don't even respect your own body. You don't respect other people. As soon as you start taking alcohol, you throw everything you have that is good away. Even your family, your wife, your children. You don't listen to what anyone tells you. I knew it all the time but I still did it because I couldn't do anything else. And that's the problem. We know what we want to do but we are not allowed to do it. Now the Indians have to have a good shaking up before they realize some of these things. But too often they die from liquor before they know what is happening. They don't learn that alcohol is a real hard medicine — bad medicine for Indian people, all of them.

To me, I would rather not take it at all because I can't handle it. If I take a drink now, I won't stop and I'll soon be back in the same boat. I'll throw away all my speeches, what I try to tell our people. I'll throw away all the good things I have learned. I have no respect for myself or anyone or anything when I hold a bottle.

It's a hard thing to say, why Indian people drink. They never made that kind of thing for themselves. The white people brought it to us, and that's why it hits us so hard.

In the meanwhile, we know what is happening. We know we can't go back to the old ways, and we know we must do something about this alcohol. But that's how strong it is. We can do nothing. A lot of people know it, even those at the detox. But they can't fight it.

I am on the street patrol right now because I believe in trying to save peoples' lives. You only live once, and you're dead for a long time. I hate to see people die like this. It's a very frustrating job. It's in my mind. Every day when I get up in the morning, especially in the winter, I always think someone might have frozen to death because we are not covering the area enough. You can miss out half an hour and lose a person. This is a terrible, hard responsibility when you are on the streets. And these people on the patrol all think like that. They are all really concerned about their people.

And of course, many are not full-blooded Indians. They are all mixed up, and not just in their minds.

I don't know that much myself. I didn't get to study much, but I feel Indian. As a person, I'm not trying to be better than anyone else. I'm not trying to beat anybody, I just want to live and I want our people to live in a good way.

White people made a big mistake, I think, when they tried to change us to a different religion, a different way of approaching the great spirits. They made a big mistake.

Every nation has its way of approaching its spirits. I can't say this or that is wrong. They have to follow their way, and I have to follow mine. But that's the way it happened here one time long ago, when the schools started. They told us, your father is a pagan — he's going to go to hell. And that is not the right thing to say.

I believe there is a certain way a person is put in this world. There is only one God on this earth. We are all gods inside this world, because God is inside of us. The God is all over, and never had no beginning. The world is God himself, and it doesn't matter who you are or where you are, that is the way it is.

That is the way Indian people believe.

We didn't have no paper. We had no gifts like writing things down. Anything we got, we got from our dreams. Like the sounds you hear when people are together. There are millions of different sounds. Indians know their medicine by dreams. They use it to save their lives.

You people, it says in the Bible, heard God talking in the old days. It is the same with us in our dreams. We hear God talking. But it is impossible to really tell you how it is for us. In fact, I had a dream one time myself, a song. But when you are an Indian, you understand what it means.

I still sing my song. It is a prayer, for me, and it's all part of life. Maybe if the younger ones could understand this, it would help them. And this is one of the things we are working for. If they could understand that, maybe things would get a little better. We try to get them interested at the cultural centre. And this is one way.

But we don't feel any special anger towards the white man for coming to our country and doing these things. Of course, individuals feel their own way, but this happened and all we can do now is try to live with it, and correct some things as we go along. This is the way we have to go. Gradually things will get better if we keep working, but it is important that we keep our own ways. Every nationality should have their own life. One person is not any better than anyone else.

What I often say to my street patrol is a person who is a drunkard is still a person. As long as he is living you have to respect him and try to help him.

I think it would help a lot if white people would try to learn about our ways, and the way we think. I like to see them at our Pow Wows. I even like to see them dance there.

I know about the old ways, and I try to pass this on. And it's at places like Pow Wow that I can do this. But a lot of good things went by that we don't remember now. In our days, we had no television or radios. Before these, we used to tell stories. And it was just like watching a television. We could see in our mind the vision of the story. Not now. Now they see everything on television. But in the times when people were still talking, you had your mind, and you could see the things in the story of away back.

Since I stopped drinking, I really have a lot of concern about the young people, and I'd like to see some elders work with me in trying to help the young ones, the ones who are going to have to work with the people themselves in the future. These are the ones who will have to face what's ahead. We are not going to live forever.

I had my last drink about six years ago and I feel good now. But alcohol is the thing which spoils all the peoples' lives. It is the biggest evil for us. So even with all the other things the white man brought with him when he came here, it is still alcohol which is the worst. Maybe it could be something else, but in my job I believe it is alcohol. I don't think any Indian can handle alcohol. I've known a lot of people. In my experience in 30 years of guiding, I guided white people who drank. They could leave a half-empty bottle sitting in their cabin, and it would still be there the next morning. But if you go to an Indian's camp, you will never see the same thing. It will be empty the next day. And it is always the same. White men have had alcohol around them for a long time, but not the Indians. It's got to be empty when he goes away. Alcohol is the big problem."

VIEWPOINT/ANDY WHITE

We want to be a part of Canada

Chief Andy White — a name familiar to Canadian members of parliament and cabinet ministers with an interest in Indian affairs — is the man up front at the Whitefish Bay reserve, some 62 miles from Kenora.

When he moved there nearly a decade ago, the reserve was run down. Heavy drinking was rife and people had lost touch with their backgrounds. Whitefish Bay was without spirit, and almost without hope.

These days the picture is radically different. Whitefish Bay, thanks in no small way to Andy, is proving Indians can compete successfully in today's society, and still hang on to and build on the old values.

For instance, it once had a fur plant financed by the federal government. The powers-that-be gave up on the company: it wasn't turning enough dollars over. Then Andy White — whose activity in Kenora until then was concentrated around the liquor stores — arrived on the scene as a counsellor.

He had no real official standing, and even less experience in how to cope, having only recently managed to climb on the wagon after years of abusive drinking. But it didn't take long for people at Whitefish Bay to realize they could hitch onto his determination and start the long climb back to normality. Andy — now 35 — proved by his own example just what can be achieved once the alcohol bottle is stoppered; and people took notice.

Today the fur plant — taken over by the Indians — runs at a profit, and 14 band members are learning how to make the long, fur-lined gloves and mukluks in the traditional way. Their products will eventually be sold on the open market. The band has its own restaurant, hair salon, and other amenities, and there's little doubt it will soon support itself.

"I'm chief of the reserve, but I still work as an alcohol counsellor on a one-to-one basis because I believe we must make our people understand what drinking has done, and is doing, to them.

The people respect my two jobs — chief and counsellor — and the government is beginning to listen when I talk about bringing in economic developments and social improvements.

When you work with an individual who has drinking problems, and you spend time with him trying to help him help himself, obviously this person must have something to do on the reserve or he'll just get drunk again. But if you have something for him, he'll work and occupy himself and this will not only help with his own problems, it will also help his people.

In fact, finding employment for people both here on the reserve and in Kenora is one of our biggest difficulties.

I arrived at Whitefish Bay about eight years ago. I went there with just my bare hands to try to help myself, and the reserve. And the big problem as I saw it was alcoholism.

The initiative to do something about it was there. I knew it. People wanted to do something, but they didn't know how. Nor did I, but someone had to go in and work with the people and try to give them guidance, so I went. Then, two natives worked on the reserve; one on welfare and the other on administration.

We started off with one individual — a hard-core person — and we worked on him, and this spread and went on during the first few months. Soon others started to notice and realize giving up drink was very much a question of admitting they had to do it themselves, with a little help, and from this one person we soon had 17 whole families trying to beat their drinking problems.

That one man was our beginning. Now we have a big group. We started meetings on the reserve. We talked. We wanted to decide how we could develop the reserve, and how we could help other alcoholics, so I was asked to run for chief. I really didn't have any knowledge of anything at all. I have no real education and what I do have is really basic: I guess you could say I dropped out.

But I have to help myself and my people, so I have no hesitation in going to Ottawa or anywhere else to talk about our problems. Last year I spoke to Pierre Trudeau about it. These government people speak to me and I can tell them our position and try to get their help. But it isn't me they see. They respect my position as chief.

The biggest problem for us, and the thing we have to deal with before we can go far with anything else, is how to beat alcoholism. And I think Indians have a different way of handling alcohol than white people.

We say this is because of our culture. We never saw alcohol before the white men came, which wasn't that long ago really.

We need people, counsellors and chiefs, who understand about alcohol so they can tell the people on the reserves and make them know the danger *before* they go to the cities, not after. They may be afraid to come into Kenora because of what they've heard.

But really there are no programs on the reserves. No-one to tell them what to do. The people must be taught about what's happening from very early days on the reserve.

I had a drink problem. I've been on the streets of Kenora: I found it tough then, and I still find it tough. I believe an alcoholic never really recovers — he goes through it almost day in and day out, and in many cases you have a bad day and the first thing that pops into your mind is drink. But I know this isn't the answer, and that's what I try to tell our people. Alcoholics have to work together.

Kenora has had a great deal of publicity, 99% bad, both nationally and internationally, but maybe the relationships between the Indian and white people are slowly starting to improve. I find, for myself anyway, that when I am talking to the officials of the town of Kenora that the understanding could be there. At least we have this, but before, when you were walking around, all you could see was prejudice. There are still white people in the town who feel like that, but not so many. Many now try to work with the chiefs, and so on, in different developments. This will benefit everyone, not just the Indians.

There is still anger, but not against the town. It's against the government. The people know the condition they are in, and they know who to blame. It was the governments who made the rules about the reserves and about everything else.

And you must remember the education we had on the reserves was very different to what you could find somewhere else. Very different. When I was in school we were taught only about God, which was no help to us. We have our own religion anyway. When you are trying to grow up and make a life, this doesn't help you very much.

Now I think the young people are beginning to be interested in learning something, and we *want* them to be able to learn. I talk to the kids, and they talk to me .. often about alcohol. And this fascinates me. I feel happy, because when I look at myself, I didn't want to talk about it. And maybe I was afraid to talk to the kids, once, because I thought I might scare them away. But they've grown up with this, and maybe they know it was worse when they were younger, and maybe they know things are slowly starting to get better.

On my reserve most people have a decent job, and they don't have to go on welfare. Mine is a little more progressive than most, and we are getting it to be a community by itself with its own shops and stores and industries, and this is the way it should be all over. Indian people, not just on my reserve, don't want to rely on the government. They want to help themselves, and many are trying very hard to do that.

We are the first Canadians. We want to be a part of our country — and it was our country first, don't forget — like everyone else. We don't want to be curiosities set on one side.

We want to be involved at a national as well as local level. But we have no-one from our people up there working in the cabinet, or anything like that. We should have. We want involvement at all levels.

Hopefully, one day we will have such people in places like Toronto and Ottawa, but not yet, or not so far as I know. But I wouldn't see myself as an Indian MP. Like I said, I don't have the education.

I'm the sort of a person who just takes chances and goes up there and does what he can. But the problem I have is I can't write. I can go out and talk, and I do, but I can't put all this down on paper so other people can read about what's happening and what we are trying to do.

But I do think the Indian people, not just here in Canada, but all over North America, need representation at a national level. Just now there is no movement to get an individual into this position. And the trouble — or a trouble — is too many people at federal level see *all* Indians as a problem. They call it the Indian problem. And this tends to further divide the differences. I think we're *still* having many problems trying to get our point of view across. Communications are very important, and we know we have to learn to use them.

The Canadian people all seem to look at us as a problem. Maybe it isn't just us who need an education. Maybe some white people need it too so they can begin to understand what has happened, and what is happening. It is not all down to us. We need interest from both sides before we can really deal with all of this.

Indians have a lot to put into Canada's culture; they have things to give too. We have a lot to offer. After all, we *are* the people of Canada. We have our art, we have our heritage and our way of looking at things. These are all useful, and we would give them.

And I don't think Kenora is special or unusual. You see problems like we have all over. We visit other towns in Canada, and we see the same things happening. But maybe everyone focuses on Kenora alone because of the incident which happened at the park — and this attention has made all sorts of problems in the past between the townspeople and us. It's easing off a little now.

But this impression everyone has that Kenora is a town full of Indian drunks is wrong. We have the drunks, they're the same ones, but white men don't see any difference between us.

George Councillor's death meant a great deal. He was a man everyone respected. All the Indian councils would listen to him and the Indians would listen to him. His death was a great loss and he is someone we can't replace.

I was very close to George and his death means very much to me. I feel it badly. He was a good friend of mine — a good friend to me and many others. We feel his death. I took it really hard because he helped me. He was a traditional person and very well respected everywhere by everyone.

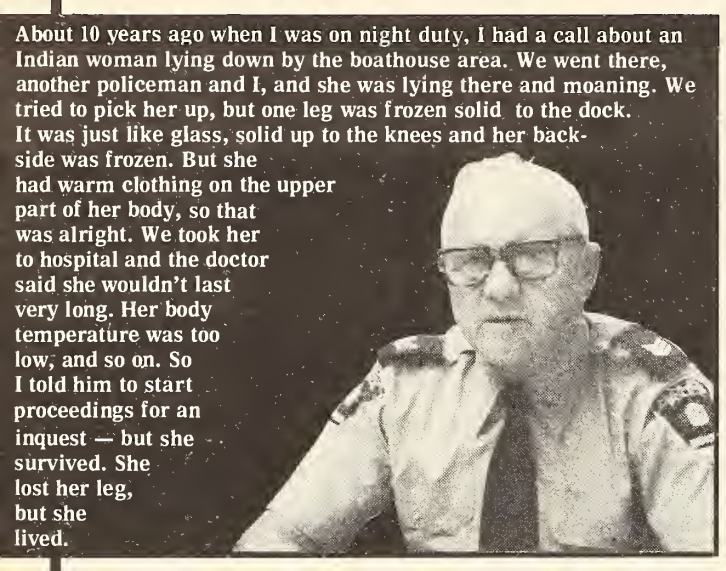
Our religion is all around us. It's in the animals, in the air, in the trees, the earth, the grass, and George knew this. I feel the same way.

On our reserve we almost lost our culture and we are trying to revive the traditional ways like Pow Wow. George gave us, and others a tremendous amount of guidance. There is no way to measure his death.

But life, our life, must go on. We must know ourselves as Indian people, and we must deal with our own problems. George knew this, and I know it, and that is the way."

VIEWPOINT/CARL HAGER

It isn't an Indian problem-- it's a community problem



About 10 years ago when I was on night duty, I had a call about an Indian woman lying down by the boathouse area. We went there, another policeman and I, and she was lying there and moaning. We tried to pick her up, but one leg was frozen solid to the dock. It was just like glass, solid up to the knees and her backside was frozen. But she had warm clothing on the upper part of her body, so that was alright. We took her to hospital and the doctor said she wouldn't last very long. Her body temperature was too low, and so on. So I told him to start proceedings for an inquest — but she survived. She lost her leg, but she lived.

Kenora police sergeant Carl Hager is an imposing man — well over six foot — who's been in uniform virtually all his working life. He was in the army during World War II, worked in the district jail after "demob," and finally started as a constable in Kenora in 1953.

At 57, he says these days he's "just a regular police sergeant running a regular shift." He's also traffic safety coordinator and liaison officer with the street patrol.

He is also a white cop with a conscience. He knows about the evils of alcohol from both the white and Indian standpoints. Every day he sees what booze can do. He says his views are his own and in no way reflect the policy of the Kenora Police Department.

"I've been around here a long time, and some of the Indian people come to me to talk about their troubles; but don't get the impression I have an open line. I don't advertise myself, although I go to the detox centre and talk to groups. But I'm one of the older policemen, and I imagine that's why some people do approach me. Maybe it's because of my age.

When the Indians took over the park, they stood the police off and reinforcements were called in from all over the province. We had about 200 here, and that's what put Kenora on the map. At this time, they wanted an officer as negotiator/go-between, and the Indians asked for me. It shows they trust me a little.

We have a pathetic situation in Kenora. It alarms me very much and this is the reason I am connected with the detox unit, and with the street patrol. I would like very much to see something done to improve the Indians' lot.

My family has a lot of personal knowledge about alcoholism. My brother died an alcoholic, so I am well aware of what it can and cannot do. He and his wife lost their lives in a fire in which alcohol was involved. I feel very strongly about this, obviously. I think maybe I can thank my wife for the fact that I don't have a problem. When I came out of the army, I drank a lot.

One of the reasons the Indians drink the way they do, in my view, is because they've always had to do it under cover and there's always been a thing where they have to get rid of it as soon as possible.

Naturally, the quickest way to do this is to drink it. Through this, it seems to me, they've developed the habit of drinking as much as possible, as quickly as possible. But we have a lot of these situations in our white community as well. They're not special to the Indians. White people are in a house — they're between four walls — but a lot of drunkenness goes on which I see because I'm in the force. So don't get the idea that all this drunkenness is just confined to the Indians. But our drunks have a place to hide, so no one sees them — except perhaps the police.

I honestly believe the only way we're going to see any solutions to any of this is for people to work with the Indians, to talk with them, to get out onto the reserves and talk to the people *before* they come into town and start their drinking careers.

We need a training program *before* they hit the streets.

Kenora is central to the reservations. An Indian will come into town after trapping to get provisions. He meets a friend who is sick and needs a drink. It's the Indian way to help, so he buys his friend a drink, and before you know where you are, he's spent all his money and is in the same condition as his friend. It's a vicious circle. The first man came in with good intentions, but now we have two of them drunk, or looking to get drunk.

This problem goes right from 12-year-olds up to the older ones. We have a couple of really old Indians who come into town drinking. I talk to them and suggest maybe it's time they quit, and they say, 'No, it soon-die time and I'm going to drink until I die.' I can name you 10 or 12 of these old people born before the 1900s.

There's one old fellow who got into the alcohol business in the last 15 years. He's a very fine old Indian, but I've watched how he's gone downhill. His manner of speaking used to be very precise, but now he's gone back to letting it all go. The words run together and slur. I've tried to talk to him, but he just says 'Soon-die time.' I say, 'Isn't that kind of foolish?' But he just answers — 'What else?'

I've been working with Indians for quite a while now. I used to coach Indian hockey teams. My sister adopted a little Indian girl, and my brother adopted an Indian boy, so if anything, I incline toward them. But some of our police hate the Indians. Maybe this is because they work with the Indians who are drunk and they're looking at the color of the person, the Indian, and not at what's causing the problem, which is the alcohol. In my opinion they should be looking at this. And it's the alcohol they should be hating, not the Indians. When Indians are sober they are very fine people.

And you can't look too hard at what the business people of Kenora say. They are primarily interested in having good conditions around the town, around the streets, so that tourists will come here.

We have literally thousands of Indians passing through, and over the years I've kept a rough index of the regulars.

I've boiled it down to around 300 who are the ones who are giving us this high drunk count. And they're the ones who'll be out tomorrow, and the next day, and the next day, which is not to say they are the *only* Indians who get drunk. But they're by far the worst offenders.

The street patrol is doing a first-rate job here, helping these sorts of people. But there's no way to measure just how good. They pick a person up and bring him in off the street — would he have died without them being around? No-one knows.

Some of our people don't feel it's worthwhile, but I disagree. And I'd like to see it run all the year around so a few more lives could be saved.

Of course we have some other problems. New legislation coming up means it won't be long before it will no longer be an offence to be drunk. There will still be room to stop a person giving a lot of trouble by going through the Criminal Code and charging him with, say, causing a disturbance. So, hopefully, we'll still be able to deal with fighting drunks. But I don't think this kind of move is the answer for an area like this. They'll come into Kenora, get drunk, and it'll be a place to sleep without fear of arrest or any kind of punishment. It will go on and on and on. Things are bad now. If this comes in it's my opinion they will get much worse.

We also hear about local youngsters urinating on drunks, or doing them actual physical damage, but a lot of this is not brought to our attention. The native people seem to feel 'What is the good of going to the police because they're not going to do anything about it anyway.'

And there is some reason for them to believe this.

This is, after all, the way some of the Indians are treated. Some of our people don't take the time to listen to these complaints when they are made. The Indians come in once, and nothing happens, so they won't come near us again.

Again, there is cause for some of these people to feel bitter or angry with the police. Some have been treated quite badly by the police. But when you have 25 men, like we have, you'll get people in there who aren't perfect. They have roughed up a few people and it has been brought to our attention. But I have always said to Indian people that if anything like this happens, come to me right away and let me know, and we'll pick these men off who have caused the trouble.

I guess I must be one of the offenders — one of the reasons why things are the way they are in Kenora. I say, what can I do? Possibly I do more than some of my colleagues by being concerned about it and recognizing it for what it is — a sickness. I feel like I'm not doing very much.

But by different groups working with the Indians and getting out and doing the job, we must make some progress. The more people know what is happening, the more chance we have of seeing things improve.

For instance, a lot of the townpeople didn't want the detox unit here at all. But since then, some have gone up for a look, and now they have no objections at all. In fact, I think we have to educate the people of our town as well as the Indians. They have to learn they can't just shut their eyes and it will go away. If they work at it, maybe they can help in dealing with the problem. They say 'The Indian problem.' But it's not that at all. It's a community problem.

Many Indian people see the re-emphasis of their own culture as a way of perhaps helping the younger ones, but I don't really see it will help all that much. There are too many other things they have going against them. If you had a reserve separated from television and so on, fine, but not otherwise. I know some of the older people would like to see exactly that.

There's one old Indian fellow who talks about how the town was in the old days and how the Indian manner of living has changed. It has changed, and you'll never bring it back. It's lost. We would like to think not irretrievably, but . . .

Maybe if our whole economy fell flat on its face, some of these things would come back. But not otherwise."

Editor... Letters to the Editor... Letters to the Editor...

Alcoholism genetic? Beware research bias

I am writing in response to R. P. Swinson's reply (**The Journal**, July) to my letter (**The Journal**, June) concerning the question of a genetic etiology of alcoholism.

Dr Swinson has correctly identified the point at issue as being whether or not the apparent prenatal factor is genetic or otherwise in origin. A prenatal effect can have either a genetic or environmental origin, and so the issue is also still one of separating a genetic from an environmental etiology. Any research design that is unable to separate the effects of these two origins cannot possibly provide evidence for either.This is the unfortunate case in, not only the adoption studies, but also all of the other research designs employed on this question.

With regard to the adoption studies, it is true, as Dr Swinson states, that most alcoholic women present for treatment in their late 30s and 40s. However, on the average, they begin to drink hazardously between the ages of 28 and 33. This is certainly an age range when many women become pregnant. In addition, Dr David W. Smith has estimated that one out of every 200 liveborn babies show some effects of alcohol ingestion by the mother during pregnancy. Also of interest is the presence in the literature of studies that show relatively high numbers of marriages in which both partners are alcoholic. Thus, being an alcoholic would seem to increase the probability of being married to an alcoholic. A study by Rosenbaum found that a third of the female alcoholics (8/25) claimed that they drank in reaction to their husband's drinking.

Given that many women drink hazardously during pregnancy and that alcoholics appear likely to have wives who drink hazardously, it may very well be that wives of alcoholics are more likely to drink during pregnancy than wives of non alcoholics. Thus, offspring may be predisposed to developing hazardous drinking habits because of maternal alcohol consumption during pregnancy and not because they have inherited a gene. At present, the evidence for this is indirect as well as weak, but the data available suggest that it is certainly a possibility. To the best of my knowledge, this question has not yet been scientifically studied.

Even if investigation failed to support this hypothesis, adoption studies are still plagued by the possibility of heavy parental alcohol consumption adversely affecting sex cells. This would clearly be an environmental origin, since the offspring would be predisposed because of parental behavior (ingesting large quantities of alcohol) and not by the independent inheritance of a gene. The relationship between germ cell damage and alcohol abuse by offspring need not even be direct. It may be that heavy parental drinking results in emotionally and intellectually less-effectively functioning offspring. Such individuals would certainly be at a high risk of using inappropriate means, such as frequent and heavy alcohol consumption, to alleviate stress. You may call germ cell damage by alcohol a genetic etiology if you wish, but I doubt that you would find a single geneticist who would agree with you.

'No evidence for genetic origin'

I have not ignored Winokur's work. It is interesting that Dr Swinson excuses his own brevity with the restrictions imposed by a short letter to the editor, while he considers brevity on my part as "seemingly on the basis of the reading of a minute portion of the evidence available." Like the adoption studies, Winokur's research design is also incapable of differentiating between genetic and environmental effects. That is, do relatives have similar behavioral and emotional problems because of similar genotypes or because of similar cultural or social circumstances? It may be that close friends, or even close neighbors, show just as high a concordance rate as do blood relatives. Although the familial pattern observed by Winokur in his lab may be consistent with a genetic explanation, other studies have not comfirmed his results (see review by Gerson et al, 1977). This suggests that Winokur may be observing cultural effects.

Thus, Winokur's research design is not able to separate the effects of genes from environment and, as I stated earlier, any design that cannot do this is incapable of providing evidence for either etiology. This problem applies to other forms of genetic investigation of behavioral problems as well, including twin studies, marker studies, and even the recently discovered protein polymorphism labelled PCI Duarte by Comings. This state of affairs leads one to the conclusion that there is at present no evidence for a genetic origin of alcoholism. However, there is also no evidence to say that alcoholism is not genetically influenced. In such a state of uncertainty, it is easy for one's biases to influence one's position. Scientists who claim to have evidence on this complex question should perhaps scrutinize their own biases.

Michael DeVillaer
Addiction Research Foundation of Ontario, Hamilton.

References attached to this letter are available on request from **The Journal.**

Let's check this controversy in 10 years

Dr Swinson replies:

There seems to be little disagreement about the data regarding the genetic influence in the etiology of alcoholism. The argument arises about the interpretation of these data.

Mr DeVillaer goes to great lengths to offer "environmental" explanations for the findings relating to the frequency of alcoholism in the adopted children of biological alcoholic parents. His argument is basically that some environmental event occurring at any time in the development of an alcoholic's child, from the period prior to conception through to adulthood, might cause the development of alcoholism and that such an event might be interpreted as being genetic in origin.

There are problems with the position Mr DeVillaer adopts. He has chosen to present the issue in polarised terms, the old positions of Nature vs Nurture, when the researchers involved in the work, myself included, have been examining the possibility of there being a genetic component to the development of alcoholism. Obviously the environment has to play a part. The research quoted in my lecture *Genetic Factors in the Etiology of Alcoholism* has examined the question of whether or not environmental factors are sufficient explanation for the development of alcoholism in the offspring of alcoholics. As Mr DeVillaer admits in his last paragraph, there is no evidence to say alcoholism is not genetically determined and thus it is reasonable to continue to offer genetically based explanations for the findings observed.

Mr DeVillaer makes the error of implying that researchers in genetics have conceptualized the genetic component in alcoholism as being due to "the inheritance of a gene." Such is not the case and does not do justice to the researchers who have carried out the work and have not made the extravagant claims Mr DeVillaer would have readers of **The Journal** believe.

Mr DeVillaer's main attack is upon the interpretation of the data regarding the findings in the adoption studies. To summarize, very briefly, these findings are that the male children of alcoholics develop alcoholism at very similar rates whether these male children are reared in the alcoholic family setting or in a non-alcoholic family. This is true even when the children are removed from the biological family within the first six weeks of life, thus effectively diminishing the importance of child rearing practices as a causal agent in the etiology of alcoholism.

These findings are complemented by the results of half sibling studies which have compared the effects of being the biological child of an alcoholic with the effects of being a child of non-alcoholic parentage reared by an alcoholic. The findings are that the variable associated with the development of alcoholism in the offspring is that child being the *biological* child of an alcoholic parent — either male or female.

'DeVillaer really goes overboard'

Mr DeVillaer's argument rests upon his assertion that an environmental variable might intervene, *in utero*, the proposed agent being high blood alcohol concentration or germ cell damage caused by high BAC. Unfortunately for Mr DeVillaer's argument, this proposition is untenable in the light of the twin studies available. Were an environmental agent, acting *in utero*, responsible for the high rates of alcoholism in the offspring of alcoholics, then those offspring sharing an intrauterine environment (ie twins), would be equally exposed to the agent and thus equally affected by it. This assertion is not supported by the evidence. If one compares the concordance rates of the development of alcoholism in dizygous DZ (two egg) twins and monzygous MZ, (one egg) twins, significant differences are found, with MZ twin pairs having higher concordance than DZ twin pairs. Restated, this means that offspring who are genetically identical develop alcoholism at rates much more alike than do offspring who are not genetically identical. Mr DeVillaer's cavalier dismissal of twin studies leads me to conclude that he has failed to understand the meaning of such studies. I refer him to Slater and Cowie's book, *The Genetics of Mental Disorders* (p 19) for an explanation of the meaning of significantly different MZ and DZ concordance rates.

Mr DeVillaer really does go overboard and abandon both knowledge and logic when he suggests that "close friends or close neighbors (may) show just as high concordance rates as do blood relatives." It makes no sense in an argument to introduce factually incorrect premises from which to develop a position. Mr DeVillaer appears to ignore the basic observation that alcoholism and affective disorders are familial disorders. That is, they occur in families and in blood relatives more commonly than in people who are not relatives. Were alcoholism and affective disorders *not* familial, then no one would be engaged in the distinction between genetic and environmental factors in the etiology of these disorders.

I agree with Mr DeVillaer that because some evidence has been found to support the possibility of a genetic factor in the development of alcoholism this is far from being proof of a genetic etiology. Further work is obviously needed to elucidate the present findings. Such work will accrue slowly due to the nature of the disorder and the difficulties involved in any human genetic studies where the disorder is loosely defined and where it occurs at a low frequency in the general population. As Mr DeVillaer implies, the relationship between a genetic factor and the development of alcoholism may be indirect. It is not suggested that "alcoholism" as such, is inherited, presumably a predisposition towards its development is implicated. The predisposition could be one of taste preference, preference for the effect of alcohol, a mood variability as proposed by Goodwin (1979) or other dimensions yet to be determined. The use of "alcoholism" as the target disorder may well only select those who are most severely at risk from the development of alcoholism and fail to detect those less at risk but who carry a genetic predisposition.

There is uncertainty about the meaning of the findings as there should be at this stage. The uncertainty is the spur to further research. Perhaps Mr DeVillaer and I can review our respective positions 10 years from now when the uncertainty may well be lessened.

Richard P. Swinson, MD
MRCPsych, FRCP (C), DPM
Staff Psychiatrist
Associate Professor
University of Toronto

RE: GILBERT

'Suffice it to say : AA works'

I am writing in response to the Gilbert column, Views on Alcoholics Anonymous (The Journal, Aug).

I believe that Tournier is concentating on problems rather than people. AA is not a scientific fellowship, nor is it a research organization. It has found a way to help alcoholics recover, so why experiment? Alcoholics are people, not guinea pigs or statistics, and alcoholism is a fatal, progressive illness. We are dealing with human lives.

Controlled drinking for an alcoholic can be a very dangerous experiment, at best. As for intervention being inhibited by AA's message that powerlessness and hitting bottom are prerequisites to recovery, every alcoholic has his own "bottom." Bottom can be wherever the alcoholic wants to be.

In answer to the Addiction Research Foundation's "anonymous," I wonder how he professes to know AA's views and "biases," when I would suppose that he is not an AA member and probably does not attend AA meetings on a regular basis, if at all.

It is only inevitable, I suppose, that sociologists and other professionals in the alcohol field are very skeptical as to how a treatment could work when it is not based on profit, research, and the all-important (?) question "why?" Suffice it to say, that Alcoholics Anonymous works.

Katherine A. Gow
Addiction Counsellor
Belleville, Ontario

NEWS

Fresheners abused as sexual stimulants

By David Milne

WASHINGTON — United States government agencies have begun investigating a group of products sold as air fresheners that are now being used primarily as sexual stimulants and drugs of abuse.

The products, composed of butyl and isopropyl nitrites, are commonly sold in small aerosol bottles in pornographic book stores under such trade names as RUSH and LOCKER ROOM.

Officials of the US Food and Drug Administration and the US Consumer Product Safety Commission are concerned over both the health hazard volatile nitrites pose,and the fact they are not marketed as drugs although they are being used as drugs.

Drug abuse expert Dr Sidney Cohen of the University of California, Los Angeles, warns that "increasing numbers of people are inhaling them throughout the day."

Since the effects last only a few minutes, they may be sniffed a dozen or more times an hour.

"The daylong inhalation of the volatile nitrites is another example of people doing to themselves what research pharmacologists would not be permitted by a university committee to do even under carefully supervised conditions established to safeguard human rights.

Increasing use of the volatile nitrites has stirred concern among federal officials because little is known about the adverse effects of inhaling the compounds.

Drug abuse officials seem perplexed about the attractiveness of the volatile nitrites.

When they dilate blood vessels they also produce pounding headaches and increased pressure behind the eyes.

The attraction may be the fact that butyl nitrite and related compounds dilate blood vessels in various parts of the body,including the brain, giving the inhaler a sense of giddiness and a feeling that time is prolonged. Hence, the feeling that sexual pleasure is extended.

While initially used as an "orgasm expander" among male homosexuals, the volatile nitrites are now being used by increasing numbers of people, often indiscriminately.

Butyl nitrite has become a part of the disco scene in large cities.

Not content with sniffing the compounds, some users have made the fatal mistake of drinking the tiny bottles of "room deodorizer."

The result has been nitrite poisoning.

Several cases, including one death, have occurred recently in the Washington area alone.

The FDA is investigating the health hazard posed by the volatile nitrites.

Based upon the investigation, the agency will determine what action it can take against substances that are used as drugs, but not marketed as drugs, and perhaps not subject to drug laws.

'Toughen warnings'

LONDON — The Health Education Council here has called for tougher health warnings on cigarette packets as well as tighter restrictions on smoking in public places.

The council says the current health warning (cigarette smoking can damage your health) should be strengthened when present voluntary agreements between the government and the industry end next year.

The HEC spent £325,000 on health education about smoking last year while the tobacco industry spent an estimated £80 million on advertising.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Jenny Cafiso, coordinator of the group, at (416) 595-6150.

I'll Quit Tomorrow

Number: 317.
Subject Heading: Alcohol and the family, alcohol and alcoholism overview treatment/rehabilitation, employee assistance programs, attitudes and values.
Details: 88 minutes (in three parts): 16mm, color, sound.

Synopsis: Some people use drugs to change their moods and many become addicted. The greatest percentage of these people are addicted to alcohol. It is called a family disease because the family unit deteriorates along with the alcoholic. This is illustrated by the story of Steven and his family. Steve's behavior becomes intolerable as his drinking increases. His work performance becomes intolerable as his drinking increases. His work performance deteriorates and his family avoids him. He refuses to go into treatment on his own, with the provision that he must enter treatment if he ever drinks again. Soon he returns to drinking and is forced into treatment. His wife joins Alanon, and his daughter joins Alateen. The whole family learns to cope with Steve's new sobriety.

General Evaluation: Very good (5.0). A well-produced, contemporary, and informative film with a clear message, it was rated as a good teaching aid. The A/V group felt the film could help in decision-making regarding alcohol abuse.

Recommended Use: Likely to benefit audiences of 12 years of age and older. Especially useful with patient groups and health professionals. Presence of a resource person is not essential but would help in facilitating discussion dealing with reactions to the film.

If You Loved Me

Number: 320.
Subject Heading: Alcohol and the family, AA, Alanon, Alateen, alcohol and alcoholism overview.
Details: 54 minutes, 16 mm, color, sound.

Synopsis: Don stumbles in late one night, and his wife Nancy, angrily asks him why he failed to call. At another party, he becomes involved in a fight. Nancy tells him his behavior is changing — he loses patience with his family, neglects responsibilities, and wants to move to another city. At the urging of a friend, Nancy attends an Alanon meeting, and discovers that her problems are not unique. Nancy refuses to go on covering up for her husband, and persists in attending Alanon meetings despite her husband's protests.

General Evaluation: Very good to excellent (5.6). A contemporary, informative, interesting, and realistic film with a clear message, this was rated an effective teaching aid. The A/V group like what the film said about alcohol and its abuse, and felt it could help in decision-making regarding alcohol use.

Recommended Use: Likely to benefit audiences of eight years of age and older. May be particularly useful with Alanon groups and families of alcoholics. A resource person is not essential, but would help in facilitating discussion dealing with reactions to the film.

Dying For A Fag

Number: 323.
Subject Heading: Smoking.
Details: 30 minutes, 16mm, color, sound.

Synopsis: Peter and his wife, Angela, live in England. Peter is 42-years-old, and has been told he has lung cancer. He started smoking at a young age, and failed attempts to quit. The film shows Angela's concern about Peter's smoking and about his inevitable death. Interspersed with Peter's interview, is another with a pathologist who is convinced smoking causes lung cancer. He shows slices of cancerous lungs from smokers and compares these to non cancerous lungs. He tells the audience that the incidence of lung cancer can be reduced significantly simply by stopping smoking.

General Evaluation: Good (4.2). A contemporary, informative film with a clear message, this film was considered a good teaching aid. Its length was considered suitable for most educational uses, and the film evoked a strong emotional response. The A/V group liked what the film said about smoking, and felt it could help in decision-making regarding smoking.

Recommended Use: Likely to benefit audiences of 12 years of age and older. Also useful with cigarette smokers and health professionals working in this field.

DEPARTMENT

New Books by RON HALL

Find Your Perfect High

. . . by John Armstrong Marshall

This book is intended for parents who would prepare their children to enter society with knowledge and responsibility; for the person who would better understand a partner's drinking habits; for the professional who would share new insights with patients; for the person who would gain social comfort and confidence; and for the person who would like to change drinking patterns. This book explains why a person wants to drink. The author's theory is that a person tends to over-rely on the half of the brain that keeps him rational, logical, and controlled. For most, drinking enables one to shut off this side of the brain in order to become fun-loving, creative, and inquisitive. By learning to shift emphasis from one side of the brain to the other one can experience a natural high.

(Clare Foundation, Inc, 844 Pico Boulevard, Santa Monica, California, 90405. 1978. 210p. $5.95.)

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Phencyclidine (PCP) Abuse: An Appraisal

. . . edited by Robert C. Petersen and Richard C. Stillman

This volume, Research Monoraph No 21, represents an attempt to bring together present knowledge with regard to phencyclidine. Neurobiology, neurochemical pharmacology, and behavioral effects of phencyclidine are examined. Papers are presented on PCP use among youth, epidemiological aspects, patterns of use, psychiatric aspects of chronic use, pharmacokinetics, diagnosis and treatment of users, and legal aspects. The monograph is intended as a compendium of information on the problems, as well as a stimulus to further work to answer some of the critical questions yet unanswered.

(National Institute on Drug Abuse, 5600 Fishers Lane, Rockville, Maryland, 20857. 1978. 320p.)

Self-Administration Of Abuse Substances: Methods of Study

. . . edited by Norman A. Krasnegor

In July 1975, NIDA held a comference on the possible commonalities inherent in four substance use patterns: cigarette smoking, alcohol drinking, excessive caloric intake, and illicit drug use. The papers in this volume, NIDA Research Monograph No 20, focus upon methodological approaches used to study self-administration of abused substances by humans under controlled laboratory conditions. The papers are divided into two major sections: drugs and ethanol, and food and tobacco.

(National Institute On Drug Abuse, 5600 Fishers Lane, Rockville, Maryland, 20857. 1978. 256p.)

Booze, Bucks, Bamboozle, and You!

. . . by Ross J. McLennan

In this book, the author comments on propaganda regarding liquor, beer, and wine, as well as prevention and rehabilitation propaganda, the prohibition era, and propaganda regarding laws, rights, taxes, and liquor conglomerates. Propoganda statements are presented and are followed by a discussion of actual information. Included in the propoganda items reported are: alcohol aids digestion, a "stiff" drink of brandy is good for a cold, black coffee or cold showers will sober one up, and beer is not intoxicating.

(Sane Press, 101 NE 23rd St, Oklahoma City, OK, 73105. 1978. 158p. $2.95.)

Drug Abuse: Modern Trends, Issues, and Perspectives

. . . edited by Arnold Schecter

This volume contains papers presented at the 1975 National Drug Abuse Conference in New Orleans. Represented are papers dealing with epidemiology, polydrug abuse, therapeutic communities, methadone maintenance, detoxification, treatment personnel, narcotic antagonists, LAAM, drug dependent mothers and infants, evaluation of drug abuse treatment, and minority issues. Other sections are devoted to women's issues, legislation, vocational issues, alcohol abuse, training, and education, community issues, legal issues, cocaine, and the basic pharmacology of marijuaa. The conference committee believes that the primary value of this volume is to fix in print the dialogue among workers in the field of drug dependence at a particular point in time.

(Marcel Dekker Inc, 270 Madison Avenue, New York, NY, 10016. 1978. 1,069p. $45.)

Other Books

Critical Concerns In The Field Of Drug Abuse — Schechter, A. Marcel Dekker, New York, 1978. Proceedings of the Third National Drug Abuse Conference, New York, 1976. Author Index. Public policy: epidemiology: prevention: evaluation: treatment, drug free, methadone maintenance, general: Issues, legal criminal justice, minorities, women, pregnancy and neonatality, parenting and child abuse, vocational issues: alcohol abuse: drugs and alcohol: polydrug abuse: family therapy: administration and management, funding, staff development: basic pharmacology: clinical pharmacology, narcotic antagonists, LAAM: Other issues — media, Britain, China, etc. 1,426p. $52.50.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

Detox Training Program — Nov 12-19, Toronto, Ontario. Information: Mr G. Gooding, Assistant to the Coordinator, Detox and Rehab Programs, Addiction Research Foundation, 33 Russell Street, Toronto, M5S 2S1.

OAPSW 15th Anniversary Annual Conference — Nov 15-17, Geneva Park, Orillia, Ontario. Information: Ontario Association of Professional Social Workers, 696 Yonge Street, Suite 501, Toronto, Ont, M4Y 2A7.

Addictions — What Is Treatment — Aug 11-14, 1980, Montreal, Quebec. Information. Vern Lang, Canadian Addictions Foundation, Suite 1100, 251 Laurier Ave. W, Ottawa, Ontario, K1P 5J6.

United States

Employee Assistance Programs: Development and Implementation — Oct 10,17,24,31, Nov 7,14,21,28, Dec 5,12, Amityville, New York. Information: Herbert Martey, Director of Training, The Occupational Alcoholism Programs Training Institute, Amityville, NY.

Alcoholism Professionals of North Carolina — Fall Meeting — Nov 1-3, Burlington, North Carolina. Information: Franklin Ingram, APNC, PO Box 14291, Raleigh, NC 27620.

Recent Scientific Developments in Drug and Alcohol Use Conference — Dec 3-4. New York, NY. Information: H. Daniel Carpenter, National Association on Drug Abuse Problems Inc, 355 Lexington Avenue, New York, NY, 10017.

4th Southeastern Conference on Alcohol and Drug Abuse — Dec 5-9, Altanta, Georgia. Information: Dr C Hunter Jr, Medical Director, Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd, Altanta, GA, 30338.

Chemical Abuse and Mental Illness: Bridging The Gap — Dec 6-7, Leamington Hotel, Minneapolis, Minnesota. Information: Diane Campbell, Dept of Conferences, 315 Pillsbury Drive SE, University of Minnesota, Minneapolis, MN 55455.

Training Institute on Addictions — Dec 9-14, Miami Beach, Florida. Information: Training Institute on Addictions, c/o Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, Colorado, 80901.

Poisoning: A Symposium — Feb 11-15, 1980. Denver, Colorado. Information: Director of Professional Education, Rocky Mountain Poison Center,West Eighth and Cherokee, Denver, Colorado, 80204.

New Frontiers in Addictive Behaviors: A Conference Cruise to Alaska — June 14-21, 1980. Information: Merry Bush, Kawaguchi Travel Service, Alaska Cruise Program Committee, 711 Dexter Horton Building, Seattle, Washington, 98104.

Abroad

African Conference on Drug Abuse — A Multidisciplinary Approach — Nov 26-30, Lagos, Nigeria. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

1st Pan-Pacific Conference on Alcoholism and Drug Dependence — Feb 26 - Mar 7, 1980, Canberra, Australia. Information: Pierre Stolz, AFADD, PO Box 477, Canberra City, ACT 2601, Aus.

National and Regional Workshop on Drug Abuse — March 10-15, 1980, New Delhi, India. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

26th International Institute on the Prevention & Treatment of Alcoholism — June 9-14, 1980, Cardiff, UK. Information: ICCA, Case Postale 140, 1001 Lausanne, Switzerland.

10th International Institute on the Prevention & Treatment of Drug Dependence — June 15-20, 1980, Cardiff, UK. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

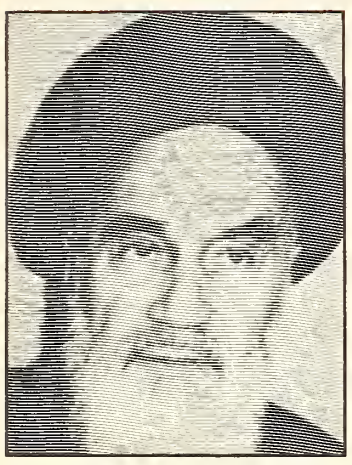
5th World Conference On Therapeutic Communities — Aug 31 - Sept 5, 1980, Noordwijker Hout, the Netherlands. Information: Robert Chevevert, Monsterweg 29a, 223 RB-s Gravenhage.

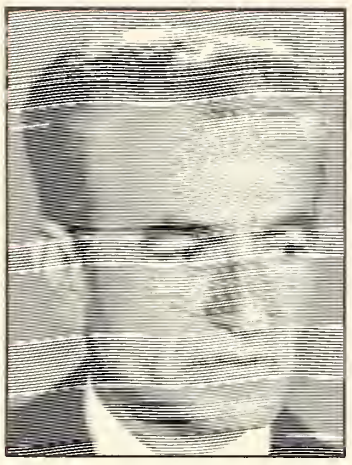
Night Driving Conditions — Nov 20-22, 1980, Paris, France. Information: La Prevention Routiere Internationale, Linas, F-91310 Paris, Montlhery, France.

33rd International Congress on Alcohol and Drug Dependence — 1981, San Jose, Costa Rica. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

IRAN

A special report by Sean Milmo





'Drug traffickers are taking advantage of political chaos to turn opium cultivation into a booming export industry...'

Opium flows under reign of fear

Drug enforcement agencies are hopeful that there will be a big drop in the export of heroin from Iran following a clamp-down by Iranian authorities on opium growing.

"Clearly they have not given up in their fight against increased trafficking and are now moving against the drug trade at all levels," said Michael Davies, chief of the illicit drugs section at the United Nations Division on Narcotic Drugs.

Large quantities of heroin started pouring out of Iran earlier this year after the revolution which toppled the Shah. Traffickers took advantage of the political chaos to turn Iran's opium cultivation into a booming export industry. For many middle-class Iranians, drug smuggling also became an easy way of getting money out of the country.

Britain appears to have become the main outlet of the burgeoning trade. About 40% of total heroin seizures by the United Kingdom Customs and Excise during the first seven months of this year came from Iran. Last year only 5% of total seizures were of Iranian origin. Around a dozen Iranian smugglers of heroin and opium are awaiting trial in Britain.

Khomeini's answer

West German authorities have also been worried about a sharp increase in the import of Iranian heroin. Previously, West Germany accounted for about 75% of exported Middle East heroin, mainly because of its large number of immigrant Turkish workers. Iranian heroin has been coming through Turkey as a result of barter trading in Iranian-Turkish border area.

Under pressure from Western drug agencies and the UN Division on Narcotic Drugs, the Iranian authorities have now cracked down on traffickers. Ayatollah Khomeini, unofficial head of State, announced the consumption and sale of narcotics was contrary to Islam. The government soon afterwards issued a new law prohibiting the cultivation of the opium poppy with offenders facing up to 15 years in jail.

Firing squad

Traffickers have been executed by firing squad in many parts of the country. Some revolutionary committees or *komitehs*, who hold power localy, over-reacted in their bid to stamp out drugs. In Shiraz, southern Iran, two men were executed for merely possessing heroin. The wave of killings sickened even Ayatollah Khomeini's son who declared that the komitehs should concentrate more on annihilating the political enemies of the revolution.

The biggest coup so far for the Iranian security forces has been the seizure of 100 kilos of heroin near the city of Hamadan in western Iran. The heroin had just been refined ready for distribution when militiamen in a helicopter swooped in on four traffickers. One militiaman and one trafficker were killed in a gun battle before the rest of the gang were arrested.

Despite this success, however, the country's security forces are hardly in a fit state to launch a totally effective anti-drugs drive. Iran has still not fully recovered from the upheavals of the revolution. The army and the police are not properly organized. The revolutionary militiamen have still to be fitted into a cohesive security structure.

Nonetheless, the upper eschelons of the anti-narcotics corps remain intact. And UN drug officials are pleased that they are still talking to the same officials as they did under the Shah. They are optimistic that with experienced people in charge, the Iranian authorities will be able to prevent a big switch among small farmers to opium growing. Opium is by far the most lucrative cash crop.

Farmers are no strangers to the crop. Opium is a traditional medicine in most areas and has been cultivated for centuries. With international traffickers looking to Iran, and neighboring Afghanistan and Pakistan, as their main sources of supply in preference to the Golden Triangle in south east Asia, and to Mexico, the temptation to take up opium growing is immense.

Under the Shah, opium cultivation was restricted to 37,000 acres. There have been reports that in the turbulence of the Shah's overthrow, the acreage has been doubled, providing a yield of around 600 tons this year. Two-thirds of this record harvest could find its way into Western drug markets.

UN drug officials believe these reports are gross exaggerations. Farmers cannot boost opium production so quickly. "Opium growing requires a lot of hard work and preparation. Above all, it is highly labor intensive," said Mr Davies.

The crucial period in the battle against opium cultivation could be during the early winter months of this year — the best time for sowing poppy seeds. The security forces have to get the message across to the farming population that opium growing is a risky business. The government also needs to offer assistance with substitute crops.

Religious hostilities

One major problem for Khomeini's regime is the concentration of the country's opium cultivation provinces like Kurdistan, Azerbaijan in the west, and Khorassan in the north east. These are all on the periphery of the country, holding large non Iranian minorities who have shown open opposition to the Khomeini government. The hostility is highlighted by religious differences, the Iranians being mostly Shia Moslems and the non-Iranians, Sunni. The Iranian army has just fought a full-scale war against rebels in Kurdistan. In these areas, keeping the population in control is difficult enough, let alone putting the fetters on opium growers.

Iran's large number of drug users also provides a ready home market for the opium cultivators. The country has around 200,000 registered heroin addicts and probably between one and two million drug users, out of a total population of 35 million. Most addicts and users live in the major cities, making distribution easier.

The Shah introduced a haphazard system of restrictions on opium growing and consumption. Certain farmers were licensed to grow opium on a limited scale. Heroin laboratories operating in the cities provided the drug for addicts at government-fixed prices. Inevitably, corruption took over. By the time the Shah was toppled, his secret police, Savak, reportedly controlled much of the opium trade.

Savak is even thought to have run drug rings, which sold some of their produce abroad. It limited the level of supplies by keeping a tight hold on farmers and stopped excessive profiteering. Though officially tolerated and even encouraged, the heroin trade was at least kept within bounds.

Once the Shah's police state collapsed, the drug trade fell into the hands of Iranians intent on making big profits quickly while the political vacuum lasted. Drug-taking almost certainly increased. A ban on alcohol by Khomeini soon after he took over did not help. Many people turned from liquor to drugs.

After Iran's revolutionary regime banned alcohol, more drug traffickers joined traditional vendors selling their wares on the streets of Teheran.

THE BACK PAGE

In the back streets of Teheran, the narcotics market flourished as never before. Addicts littered the pavements and alleyways around the city centre. Inexperienced Iranian revolutionary guards took little notice of drug users huddled around heated strips of aluminium foil sucking fumes through straws.

Khomeini's crack-down on opium consumption is unlikely to make any difference — except to drive drug taking underground. The government shows no sign of initiating any rehabilitation or treatment schemes. On the contrary, it appears to want to abandon any idea of medical cure altogether. Instead, it is putting its faith in the fear of punishment to snuff out the use of drugs.

Explaining the Ayatollah's ban, Health Minister Kazem Saami said that no more addicts would be added to the government register. "We will gradually suspend these permits until, within an acceptable period of time, the register will no longer exist."

Until the authorities start to get a grip on its substantial drug problem, Iran is going to continue to be a dangerous source of supplies for the international heroin trade. Drug experts in Western Europe hope that, for the moment at least, Khomeini's religious fervor will stem the outflow. But the core of the problem looks likely to remain untouched.

Court hits BC heroin treatment

By Tim Padmore

VANCOUVER — The Supreme Court of British Columbia has struck down the province's heroin treatment act.

And in so doing, it may have swept away the right of any province to pass legislation providing for treatment of narcotics addiction.

The provincial government is claiming that the successful constitutional challenge makes all narcotic treatment programs a federal responsibility.

For a time, the discomfited challengers agreed but they now argue that the judgement permits voluntary programs.

Jim Dybikowski, past president of the BC Civil Liberties Association says a transcript of oral remarks made by chief justice Allan McEachern, after his decision, proves the point.

Mr Justice McEachern ruled that the heroin act went beyond the powers of the province because it invaded the field of criminal law and created a new crime of narcotic dependency. Criminal law is a federal responsibility under the British North America Act.

He also ruled that the true subject matter of the federal Narcotic Control Act is narcotics, not just narcotics control. Under the residual powers principle, that can be taken to mean the federal government has already pre-empted the specific area of narcotics, including treatment for narcotics dependency.

But in his remarks, Mr Justice McEachern said he found no provision in the heroin act for voluntary treatment. Therefore, the question of the constitutionality of voluntary treatment was not decided.

Where things stand
Page 3

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The Journal

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New heroin wave is headed here

By Harvey McConnell

WASHINGTON — The United States and Canada must prepare for a new wave of trafficking in high grade heroin from the Middle East.

There is evidence heroin from Iran, Afghanistan, and Pakistan — which has caused the current heroin epidemic in Europe — has reached the North American east coast as well as the San Francisco area, according to Lee Dogoloff of the White House domestic policy staff.

Mr Dogoloff, who recently conferred with West European governments and commanders of American NATO forces in Europe, told **The Journal**: "The over-production in these three countries is critical for both the US and Canada. The heroin is of a much higher grade than we have been seeing. This situation means we have got to redouble our efforts to think about the problem in global terms."

A key is the United Nations Fund for Drug Abuse Control (UNFDAC) and its programs in opium producing areas. Mr Dogoloff said US aid to UNFDAC should be increased. A number of European countries, especially West Germany, are ready to provide more substantial aid.

"For these reasons, it is a bit disconcerting that Canada has, in fact, reduced by half its contributions to UNFDAC. All of us need to do more," he added (**The Journal**, Nov).

There is general agreement that no matter how good domestic law enforcement and treatment, the major impact can come only from international cooperation and the multilateral aid opportunities the UN provides.

Lee Dogoloff: Middle East over-production expected to surface in North America.

Mr Dogoloff pointed out the political situations in the three producing countries make it very difficult to provide bi-lateral US aid. "The situations make it a lot easier for illicit production and trafficking to flourish and underscore the necessity for UN involvement."

Mr Dogoloff said West German officials "have publicly stated that heroin trafficking is a problem that is equal in severity and magnitude to terrorism — and you have to understand the gravity of that statement — and (they) have a great desire to work in the international forum to deal with their heroin problem."

West Germany expects at least 600 heroin overdose deaths in 1979, compared with an estimated 300 to 400 in the US. "This far exceeds, on a rate basis, that which we have ever had in terms of heroin addiction," Mr Dogoloff said.

While British officials have said informally that the United Kingdom now has an estimated 10,000 heroin addicts, and Switzerland has ranked heroin use as its number one domestic problem, "there is still a fair amount of denial of the problem in Europe. This is not being critical because we denied . . . the existence of the problem until we had to deal with it."

Paradoxically, Mr Dogoloff found a decline in use among American forces in Europe even though servicemen have easy access to drugs.

"Our military has taken the issue very seriously and you can see on a graph that as the number of urinalysis tests go up — and they have increased substantially in the past 18 months — the number of identified positives comes down."

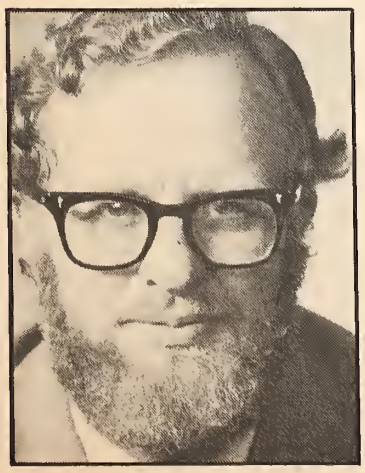
"Our generals are not only convinced they have drug problems but also that it is a long term problem. They now think urinalysis is an effective deterrent and must be continued."

PCP still a puzzle, NIDA says

By Harvey McConnell

SAN FRANCISCO — Recent studies by the United States National Institute on Drug Abuse (NIDA) have cast serious doubts on conventional wisdom concerning phencyclide (PCP).

Robert Petersen, assistant director of research at NIDA, told the National Conference on the Problems and Prevention of PCP Abuse here that the studies have raised a number of medical and social questions to which there are still no satisfactory answers.



Robert Petersen: PCP user more likely to be victim than initiator of violence.

A NIDA-financed study in Chicago, Philadelphia, Miami, and Seattle has found the majority of users start in early adolescence and stop by the age of 16. At the same time, most maintain sophisticated, controlled use and realize the dangers of memory loss and the inability to think clearly caused by chronic PCP use.

Researchers need to find out why PCP is especially appealing to those in early adolescence, what mental functions are impaired in what way, and how persistent are the effects.

Dr Petersen said the study reveals that while "the media and some clinical reports have emphasized highly destructive behavior, allegedly resulting from PCP use, users themselves minimized this tendency. Most of them stressed the fact that PCP was so disruptive of their coordination that their ability to be violent was very limited. In their view, the user was more likely to be the victim of violence than its initiator."

Those interviewed in the study felt that most violence was the result of panic reaction when police or hospital personnel used physical restraints in anticipation of violent behavior.

"If this is, in fact, often the case, it may be important to alter our guidelines for law enforcement personnel and others who may come in contact with PCP users," Dr Petersen added.

One of the paradoxes that NIDA has to deal with "is that PCP's reputation for having unpredictable or even severe adverse consequences is part of its appeal to many." Educational material which has stressed possible severe consequences "has simply not been believed, especially by those directly familiar with PCP's effects," Dr Petersen noted.

"As with other drugs of abuse, the distinct possibility exists that the publicizing of a drug's effect may paradoxically encourage use rather than discourage it," he said.

There is no question PCP can precipitate a psychosis in some, but the extent to which it does so is simply unknown. "We do not even know if the drug is directly causal or whether such an outcome is the result of a pre-disposition to a psychosis," he continued.

Cannabis reform fading fast

By Jeff Carruthers

OTTAWA — Canada's long-awaited marijuana reform, which seemed so close during this spring's federal election campaign, is fading again and probably won't reappear until late 1980 at the earliest.

Justice Minister Jacques Flynn has announced that any changes in cannabis possession charges are being delayed until federal health department experts can review recent health studies on the drug.

He told a Commons committee that previous all-party agreement was based on facts different from those now available, and new evidence suggests cannabis may be more dangerous to health than was believed a year ago.

Provincial attorneys-general had requested the delay in the legal reforms until further medical studies could be undertaken.

In a move to stir up public debate, federal Health Minister David Crombie is planning to publish a 20-page "discussion paper" on the legal and medical implications of cannabis.

New Democratic Party justice critic Fonse Faour argued the Conservatives were missing the point of cannabis reform.

He stressed the focus has been on criminal justice and criminal record implications of the current cannabis laws, not on its health issues.

Transferring cannabis from the Narcotic Control Act would allow the elimination of the criminal record stigma for first offences in simple possession cases while at the same time discouraging trafficking and importing.

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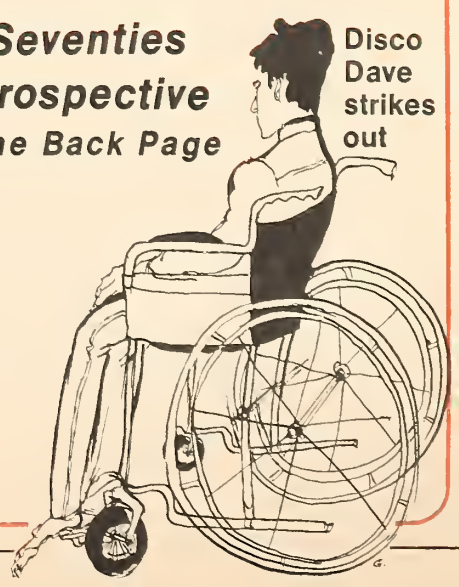


NEWS

Methadone promise is unfulfilled

By Jon Newton

TORONTO — Methadone in the treatment of opiate addiction is not the wonder cure it was thought to be and might even be perpetuating the problem.

This was the main thrust of an argument presented to researchers and medical staff at the Addiction Research Foundation last month by Irving Lukoff, professor and co-director of Socio-cultural Studies at Columbia School of Social Work, New York.

An outspoken critic of the methadone program and of much of the research leading up to its world-wide adoption, Professor Lukoff said the drug was seen originally as the possible answer to a burning question of the day: was there a crime problem, and if so, was it directly related to drug abuse?

The result was that scientists and their allies jumped in with both feet and became involved in a program which could well be described as pernicious. Methadone at street level, said Professor Lukoff, simply did not operate in the way its proponents thought it would.

"Large numbers of addicts have integrated the treatment system with their street life — they get the drug and sell it as soon as they get on the streets," he stated.

Virtually all the people registered on methadone programs in the United States are on welfare in one form or another. This means 28,000 are being supported by the state, and are still using drugs.

"So they're not really getting back to productive work," he continued. "They're hanging around the streets; they've got a basic maintenance income and they just hustle a little bit when they need more money.

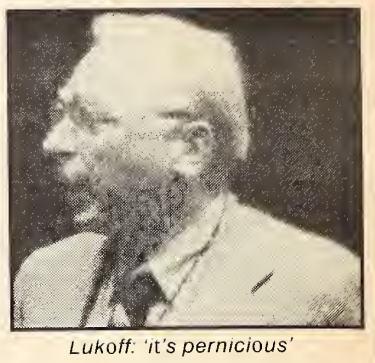
"Those who are really into crime tend to continue that way.

"Anywhere from 20% to 50% have a major alcohol problem and most of them on occasion are able to overcome the so-called blockade provided by methadone — they use other opiates as well — as the occasion demands and funds become available."

Before the introduction of methadone, heroin addicts usually found the older they got, the more painful their experiences became. This tended to result in their adopting more conventional lifestyles and perhaps easing their way into normal patterns of behavior.

"I think we've developed an institutional system which, for many, if not all addicts, stabilizes their adolescence," he said.

"So we find 40-year-olds still hanging around the streets supported by a wine bottle, methadone, welfare, and occasional hustling. These people would not have been doing this at the rate they are if it wasn't for the methadone program.



Lukoff: 'it's pernicious'

"We know that in all forms of deviance and psychopathology those who survive into old age tend to become increasingly conventional. But methadone has actually intervened in this."

Drug-free programs may not have such an impact on addicts' lives, but they don't add another complication increasing the difficulties of rehabilitation, he said.

Professor Lukoff argued there was research available in the days when methadone was first being considered which should have warned workers of its potential dangers.

"I'm saying it was already well documented that heroin use was not a compulsive activity. But certain individuals believed differently. This is where the problem of where you acquire your knowledge becomes difficult."

Political pressure forced some to grab hold of methadone as a means of dealing with what seemed to be rising crime statistics caused by increasing drug use. Others sincerely believed methadone was the therapy of choice.

Now, added Professor Lukoff, the only thing which seems to be going for methadone therapy is the fact addicts themselves are dropping out of programs at a high rate, and so may be doing more to solve the difficulties than professionals.

Evidence confirms Pill, smoking don't mix

WALNUT CREEK, Ca — New evidence indicates that women on the Pill should not smoke and that doctors should warn them of the possible consequences, according to a recent study by the Kaiser-Permanente Hospital in Walnut Creek.

In a follow-up study of more than 16,000 women over more than six years, a team headed by Savitri Ramcharan found that smoking significantly increases the risk of heart attack, brain hemmorrhage, other strokes, and blood clots.

Use of oral contraceptives by non smokers was not associated with increased risk of any of these diseases.

Smokers were found to have a relative risk of 2.9 for heart attacks, 5.7 for brain hemorrhage, 4.8 for other strokes, and 3.9 for blood clots, based on a scale devised by Dr Ramcharan.

In oral contraceptive users who also smoked, the relative risk for brain hermorrhage jumped to 21.9.

In the study, conducted in cooperation with the United States Center for Disease Control, Atlanta, Ga, other factors associated with increased risk of heart attack were high blood pressure, high cholesterol, obesity, gallbladder disease.

But only high blood pressure and high cholesterol were associated with risk of other strokes.

4 of 10 new AA members are women

LONDON — The latest British "expert body" to confirm the apparent rapid rise of alcohol problems among women is Alcoholics Anonymous.

The fellowship, which usually maintains a discreet silence, has issued a report of a summary of its members. The research shows that women are now accounting for nearly four in every 10 new AA members. And one third of the fellowship's total membership is female, compared to one fifth in a similar survey in 1972.

"The proportion of women in the AA's estimated 18,540 membership is also steadily increasing," the report adds. And a breakdown of occupations shows that sales, secretarial, and clerical workers have the biggest alcohol problems (33% of total); closely followed by housewives with 28% and women in service industries with 10%.

The AA general secretary, Bill, cautioned that the figures should not be taken as proof that more women are drinking. "It could just be that more are seeking help," he told a press conference. "However, I believe that alcoholism is accelerating among women."

He added that another key finding of the survey was that the average age of AA members had fallen from 47 to 44 since 1972. Under 25s account for about 1% of membership. But the proportion of newcomers is rising. One third of the present fellowship members joined during the last two years.

Dirty drugs infect addicts' heart valves

CHICAGO — Addicts who inject drugs directly into the bloodstream incur the risk of infected heart valves that eventually have to be replaced by complicated, costly surgery, usually at the tax payers' expense, according to a recent study.

A study by heart surgeon Charles Campbell of Michael Reese Hospital and Medical Center reveals that dirty drugs and contaminated drug paraphernalia invariably harbor virulent bacteria that journey via the blood to the heart where they colonize and destroy the valves.

Since the valve-dwelling bacteria, such as *Pseudomonas* species, stubbornly resist treatment with antibiotics, they destroy the valves which must be replaced with artificial valves by a highly skilled surgical team operating for at least five hours, according to Dr Campbell.

The surgery is complicated, the recovery, long.

Since sick addicts seldom have health insurance, the hospitals which save their lives have to pick up the $100,000 expense bill, he said.

Larry Floggit hosts the booze ad awards...

By Wayne Howell

Ladies and gentlemen, the chairman of the Academy's Board of Directors, Mr Larry Floggit. APPLAUSE

"Thank you. It's always an honor for me to host this gala evening when, once again, the Academy of Booze Advertising Arts and Sciences recognizes outstanding achievement in the marketing of alcoholic beverages. I know you're as excited as I am, so without further ado I'm going to go right to the first category of the evening — Outstanding Achievement in Lifestyle Advertising. And the winner is . . . . . Smirnoff Vodka Producers, Huck, Sterr, and Vine Advertising Directors." APPLAUSE

Accepting on behalf of Huck, Sterr, and Vine is one-half of America's favorite young couple next door, Ms Cindy-Lou Martin. APPLAUSE

"Gee Larry, what a thrill this is to be all dressed up instead of wearing my paint-splattered jeans. Brad really wanted to be here too Larry, but he's busy hanging up that neat new planter we bought. You know Brad, always working around the house. So I said, 'Brad honey, I'll just run up to that ol' presentation and as soon as I get back I'm going to sit down on the porch swing with you and we'll go kind of mooney-eyed over each other and quaff our latest Smirnoff concoction-of-the-month and admire your latest household project just like we always do.' But before I rush on home to my Brad, I'd just like to thank all those super copywriters and art directors down at Huck, Sterr, and Vine, for showing America that you can incorporate liquor into a laid-back lifestyle just as easily as you can into a sophisticated one." APPLAUSE

"Thanks Cindy-Lou. And now for the next category — Outstanding Achievement in the Social Snobbery Class. And the winner is . . . . . Puerto Rico Rum Producers, Withit, Vogue, and Snazz Advertising Directors." APPLAUSE

Accepting on behalf of Withit, Vogue, and Snazz, is the slender and sophsticated Carmen Bonnatinaldo and her suave husband Roberto. APPLAUSE

"Larry, we almost didn't make it. You know, of course, that Roberto and I are intimates of a great many celebrities who are forever telling us about wonderful new ways to enjoy Puerto Rican rum. Well today, just as Roberto and I were dashing out of our ultra-modern apartment high over Manhattan to come down here, who should phone up but Pope John Paul to tell us about this absolutely super rum drink they're just going wild over at the Vatican. Well if it had been Jackie O, or Truman, or Liza Minelli, I would have said, 'Got to run, catch you later at Regine's,' but well, you know how it is Larry, him being the pope and all. Anyway, we did make it on time and I'm just so thrilled and excited that . . . . oh . . . . . I'm crying . . . . ."

"As you can see ladies and gentlemen, my lovely wife has been overwhelmed by this honor the Academy has bestowed upon us. But I know I speak for both of us when I say thanks to those creative people down at Withit, Vogue, and Snazz, for showing all those ordinary folk who keep getting turned away from the doors of Studio 54 just what it is they're doing wrong." APPLAUSE

"Thank you Carmen and Roberto. Aren't they a lovely couple? And now we turn to the third category of the evening — Outstanding Achievement in Blatant Appeal to Intellectual Snobbery. And the winner is . . . . . Dewar's Scotch Whisky Producers, Subtle and Szell Advertising Directors." APPLAUSE

Accepting on behalf of Subtle and Szell is Amanda Watson, a 28-year-old black woman with degrees from MIT and the Sorbonne, currently employed as a special advisor to NASA, when she isn't enjoying her favorite hobbies of hang-gliding and paleontology. APPLAUSE

"Larry, I'd just like to thank the absolutely super people down at Subtle and Szell for having the vision to create that wonderful series of ads in which you see young, good-looking, well-educated people like me with interesting jobs and fascinating hobbies drinking Dewar's Scotch. I like to think that we're showing all those poorly educated, not-so-good-looking people out there with stupid jobs and boring hobbies just what it is that makes the difference." APPLAUSE

"Thank you Amanda. And now for the final event of the evening. As you know, the Venture and Luster Memorial Award perpetuates the memory of Adam Venture and Wanda Luster, that charming young couple who were tragically swept to their deaths by an avalanche while they were enjoying a well-earned Canadian Club after having just scaled the Matterhorn in full SCUBA gear.

After prolonged deliberations, the Academy of Booze Advertising Arts and Sciences has decided not to give out the Venture and Luster Memorial Award for Outstanding Achievement in Insulting the Intelligence of Magazine Readers. Why? There were just so many outstanding submissions that the directors of the Academy felt it would be unfair to single out one over the others." PROLONGED APPLAUSE

BC's compulsory treatment virtually dead

By Tim Padmore

VANCOUVER — The theoretical implications of the British Columbia Supreme Court decision (see page 1), on the heroin act are great both in the field of narcotics treatment and the area of constitutional law.

For the moment, as a practical matter, this is how things stand now, pending completion of the appeal process:

- The voluntary and court referral parts of the BC plan, the only ones implemented thus far, will continue. An order-in-council will be written transferring authority for the programs to the Alcohol and Drug Commission Act.
- The ADC Act may now be vulnerable to constitutional challenge as well. But it is unlikely to be attacked. The only section likely to injure someone and thereby give them "standing" to sue is a recent amendment providing for the subpoena'ing of treatment records. So long as the commission refrains from exercising the provision, the Act is probably safe.
- Other provinces will continue with existing programs, but may participate as intervenors in the upcoming appeals. The federal government has already indicated it will do so; they would like to see the provinces continue to implement — and pay for — voluntary programs.
- Meanwhile, compulsory treatment in BC is virtually dead.

Compulsory treatment has become a political albatross for health minister Bob McClelland, who introduced it and he will be grateful for a chance to cut it loose.

In a year or so, when the constitutional issue is settled, he will be able to do so gracefully, because by then the heroin program will be transformed.

For background on BC's compulsory treatment program, see The Journal, July, 1978, The Back Page; and, in 1979, April, page 3; Aug, pages 1 and 7; and Sept, page 1.

Already it is no longer a "heroin" plan. It is accepting abusers of everything from alcohol to Valium. In at least one large clinic, heroin users are a minority.

There is a large potential: while official estimates of the number of heroin addicts in BC may have been exaggerated to justify the heroin plan, there is no shortage of "substance abusers."

Running at half capacity now, despite a burden of adverse publicity, the program could be much busier in a year. (Either that, or the scale of the program will be changed to make it seem busier.)

The plan was conceived to treat up to 2,500 addicts at one time. Today there are approximately 120 in treatment.

There also are about 180 people on methadone maintenance. They have been carried over from earlier programs and are technically not part of the heroin plan, but some clients are using its counselling services and other programs. A few have transferred into the "drug-free" heroin plan and given up methadone.

It has been hoped the numbers would be swelled by addicts referred from the court system under agreements being negotiated between the provincial and federal governments.

At present, referrals are possible only during sentencing or as a condition of parole; the aim is to make the option of treatment available earlier in the judicial process.

Privately, many in the heroin program are relieved by the Supreme Court decision. It removes the stigma of compulsory treatment and will make it easier to broaden the scope of the program.

"It was the best thing that could have happened to us," said one.

Alcohol still hits Swedes

ACAPULCO — Despite pioneering legislation against drinking and driving, alcohol continues to be the number one factor in road accidents in Sweden and other Scandinavian countries.

Valeri Surell, director of Sweden's Abstaining Motorists' Association (AMA) and secretary general of the International AMA, said a punishable alcohol level was about 17 times more common in drivers involved in road accidents than among motorists generally, and 28 times more common in drivers guilty of traffic violations.

Drinking and driving is still a major problem in Stockholm and other parts of Sweden, but things are looking a little better: a smaller percentage of drivers are driving with 0.5 ml of alcohol in their blood, according to police.

But in spite of the depressing figures, said Mr Surell at the Third World Congress of the International Commission on Prevention of Alcoholism and Drug Dependency here, the overall picture isn't quite as bleak as it first appeared.

"Although alcohol remains the major proven accident factor in Swedish road traffic, and reaps hundreds of victims every year, the situation is, in international terms, still fairly favorable."

The limit in Sweden is 0.5 ml of alcohol, but recent random spot-checks by police showed only about 0.2% of motorists had blood levels over the limit, he continued.

But "the percentage of these drivers who had an alcohol level of 0.5 ml or more comprised about 3% of the road accident cases and 5% of traffic violations," he added.

The forests are alive with magic mushrooms

QUEEN CHARLOTTE ISLANDS — The brooding rain forests of these islands were alive this fall with treasure hunters looking for something even more valuable than the gold that is said to pepper the island hills.

They were hunting mushrooms, a breed known as magic mushrooms for the psychedelic drug they contain. They're worth $4,000 a pound in the big city and, because of a legal freak, may be perfectly legal.

The reason? While thousands of pale creamy buttons were pushing up through the ground, county court judge R. T. Low in Prince Rupert was upholding an earlier ruling that the Food and Drug Act does not prohibit possession of the magic mushroom, but only of the derivative chemical psilocybin.

The Crown is appealing the decision and the RCMP have been instructed to continue laying charges. But no trials will be held unless the appeal is won.

Dozens of pickers from as far away as Ontario were camped out on the flats near Massett.

"They're like locusts," said hunter Mernie Furst, who complained that geese and other game birds have been frightened away from their normal haunts.

Psilocybe mushroom highs have been a local tradition for several years and doctors have treated hundreds of people for after-effects.

Psilocybin can cause the kind of bad trip associated with LSD. Simple overdoses produce chest and abdominal pain, diarrhea, and induced psychosis.

Combined with alcohol, the mushrooms can kill. People become semi-conscious and may aspirate their stomach contents. Others fall victim to toxic mushrooms they mistake for Psilocybes.

Cigarette smoke reduces proteins

By Ellen Redd

LEXINGTON, Ky — Cigarette smoke appears to affect adversely the body's ability to manufacture proteins, either by directly interfering with protein synthesis or by reducing oxygen levels in the cell so the energy molecules needed for synthesis cannot be produced.

Ruby J.B. Garrett and M.A. Jackson of the University of Kentucky College of Pharmacy exposed several groups of laboratory rats to either 15 or 60 puffs of cigarette smoke at the rate of one puff per minute. The puffs were generated by a "single-port reverse smoking machine" which simulates puffs taken by human cigarette smokers.

Some rats were exposed to unfiltered smoke, some to smoke delivered through cambridge filters which remove particulate matter, and some rats received smoke filtered through charcoal, which removes some gases. An additional group of rats was exposed to pure carbon monoxide at levels comparable to those in cigarette smoke.

The researchers then measured protein synthesis in the liver, which is the major site for breakdown of foreign chemicals before their removal from the body.

Results showed that protein synthesis was significantly reduced after only 15 puffs of smoke, as compared to unexposed control rats. The more smoke the rats received, the greater the reduction in protein synthesis.

The researchers noted that neither filter eliminated the inhibiting effect of smoke on protein synthesis. Their speculation that the effect was caused by some component of smoke not removed by the filters was borne out when they examined those rats exposed to carbon monoxide alone. In that group, liver protein synthesis was definitely affected.

The researchers said the inhibitory effect of smoking on protein synthesis probably changes with chronic exposure to cigarette smoke. They said additional research is needed to clarify the means by which smoking affects protein synthesis in the liver and in other major body organs, as this knowledge would have significance for cigarette-smoking patients who are receiving drug therapy.

Anti-diarrhea drug abused

TOLEDO, OHIO — A commonly prescribed anti-diarrhea agent has great potential for abuse, warns a doctor who has reported the first case.

The drug, which is a meperidine derivative, has opiate-like effects yet is easily obtained from doctors merely by complaining of diarrhea, says Jonathan S. Rubinstein of the department of psychiatry at Olive View Medical Center, Sylmar, Ca.

Writing in *The Western Journal of Medicine* (Aug) he describes the case of an ex-heroin addict who found he could get high from taking large doses of his wife's anti-diarrhea medicine.

He consulted the Physician's Desk Reference, found the medicine contained an opiate, and then told his doctor he was going abroad for an extended period and asked for something to combat diarrhea. The doctor wrote him a prescription for a large supply of the drug whose trade names are Lomotil and Colonil.

Dr Rubinstein warns that unless doctors are aware of the potential for abuse, this drug could become very popular among certain addicts.

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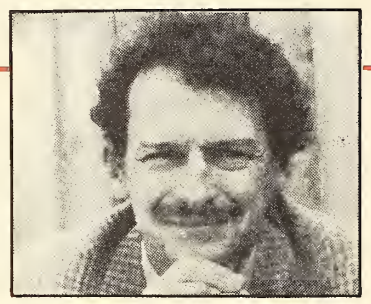
A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.



GILBERT

'Half the people who are driving while impaired are essentially immune from prosecution . . .'

Lower the legal limit

By Richard Gilbert

If you are so foolish as to drive a car in Ontario between 9 pm and 3 am, roughly one in seven vehicles you encounter will be driven by someone who has more than 50 milligrams of alcohol in each 100 millilitres of her or, usually, his blood. This is the level at which, according to laboratory studies, there can be clear impairment of the skills involved in driving.

Half of these drivers, roughly one in 14 of those on the road, will be committing the criminal offence of being in the care and control of a motor vehicle "having consumed alcohol in such a quantity that the proportion thereof in his blood exceeds 80 milligrams of alcohol in 100 millilitres of blood" (Section 236 of the Criminal Code of Canada).

The other half, while not committing an offence under Section 236, will, if the laboratory evidence is anything to go by, be committing an offence under Section 234 of the Code, which forbids driving "while . . . . . ability to drive is impaired by alcohol or a drug."

Because the courts usually require evidence of erratic driving or inebriation, charges are rarely laid under Section 234 unless consumption of alcohol has been so high as to cause the blood-alcohol level to go above 80 milligrams per 100 millilitres (80 mg%). Thus it appears that half the people who are driving while impaired are essentially immune from prosecution. Indeed, because charges are not usually laid under Section 236 unless the blood alcohol level is found to be above 100 mg%, many more than half of the impaired drivers on the road can be considered to be immune from prosecution.

Evidence

The question arises as to whether the legal blood alcohol limit should be lowered to 50 mg% in order to allow the possibility of conviction of most of the impaired drivers on our streets. Before arguing for a lower limit, it might be useful to look more closely at the evidence that impairment is evident when the blood alcohol level is 50 mg%.

A comprehensive look at this evidence, and, indeed, at all matters related to alcohol and driving, is to be found in a soon-to-be-published monograph entitled *Alcohol, Drugs and Traffic Safety*, prepared for the Organization for Economic Cooperation and Development (OECD). Recent laboratory studies are reviewed in this report in a section that concludes:

"*. . . when variables are examined which are sensitive to the effects of alcohol, such as information processing, division of attention, or visual search or tracking under dual task conditions, impairment is found at BACs (blood alcohol concentrations) below 50 mg%. Since the nature of these deficits is in perception and central information processing, the fact that the individual is impaired at these low BAC levels may not be apparent to either himself or police authorities.*"

The OECD report also reviews evidence of blood alcohol levels of drivers actually involved in accidents. There seems to be general agreement that, taking all drivers into account, the probability of being involved in an accident is higher when the BAC is 50 mg% than when no alcohol has been consumed. This general statement does not apply to every individual. People under 24 years who drive infrequently and drink infrequently are as much as 10 times more likely to have an accident if their BAC is 50 mg% than if it is 0 mg%. People aged 35 to 54 who drink and drive every day may be no more likely to have an accident when their BAC is 50 mg% than when it is zero, at least according to some studies. The OECD report takes the cautious view that, "for all classes of drinkers, the probability of having an accident increases with any departure from zero BAC." It recommends that "80 mg% should be the maximum level of legal impairment that is acceptable within OECD countries, with 50 mg% as the preferable level."

The level limit is already 50 mg% in many countries, including Australia (one state only), Bulgaria, East Germany, Greece, Holland, Iceland, Japan, Luxemburg, Norway, Poland, Sweden, USSR, and Yugoslavia. Where studies have been done, it has usually been found that introducing or lowering a legal blood alcohol limit has had the effect of reducing the amount of drinking and driving and the number of alcohol-related accidents.

Advantages

Lowering the legal limit in Canada to 50 mg% would have the following advantages:

1. It would reinforce the increasingly popular view that drinking and driving are incompatible. A recent Australian study showed that, in a university population, driving under the influence of alcohol was regarded as a more serious matter than theft, drug smuggling, assault causing grievous bodily harm, forgery, and carnal knowledge of a consenting girl. Only murder, armed robbery, rape, burglary, manslaughter, embezzlement, and living off immoral earnings were regarded as more heinous. A Canadian study would likely show similar results. Yet, in Canada, people know that they can drive with impunity after consuming three and possibly four drinks. Lowering the limit to 50 mg% would mean that prosecution could follow driving after taking any more than one drink.

2. It would reduce a growing problem of accidents caused by combinations of alcohol and other drugs. A West German study found that medications may be causing more accidents than alcohol. A report about to be published by the Traffic Injury Research Foundation in Ottawa shows that 16% of a sample of accident victims in Ontario had been taking alcohol and another drug. The effect of such drug combinations on driving skills has been inadequately studied, but the evidence, such as it is, points to enhancement of alcohol effects by antianxiety drugs, hypnotics, antipsychotic drugs, marijuana, painkillers, and antihistamines. Thus some drivers may be seriously impaired even when their BAC is below 50 mg% because another drug has been taken.

3. It would likely reduce the number of alcohol-related accidents, which, in Ontario, vary between 3% and 60% of all accidents according to whose estimate you take. A reasonable view is that 20% to 30% of the 324,000 reported accidents in Ontario in 1978 involved alcohol as the main or as a contributing factor. If a lower legal limit reduced the amount of driving after drinking by 30% — not an unreasonable estimate in view of other countries' experiences — there might be some 25,000 fewer accidents in Ontario each year.

Action

This is not the first call for a lower legal limit. Indeed, two Canadian researchers have argued that the limit should be as low as 40 mg%. This would be impracticable because analyzers are not sufficiently reliable when the BAC being measured is below 50 mg%. In May 1978, the Ontario Government announced that legislation would be introduced to give police authority to confiscate a driver's licence for 24 hours on the spot when a breath screening device registered a BAC of 50 mg% to 80 mg%. The legislation has not yet been introduced, perhaps because it would be giving police too much power. A better strategy would be simply to lower the legal limit, meanwhile increasing the apparent probability of being caught. People would drink or drive less as a result. Either reduction could be of benefit to society.

Editor... Letters to the Editor... Letters to the Editor...

Antabuse, Temposil death risk

TORONTO — Doctors using Antabuse or Temposil in alcohol aversion therapy may be unknowingly exposing patients to high risks, including death, warn experts at the Addiction Research Foundation of Ontario (ARF).

Any physician or therapist contemplating prescribing either drug should first run patients through a thorough and comprehensive screening program to ascertain cardiovascular, renal, and liver function.

And the drugs should *not* be used as the sole means of treatment.

These warnings come after in-depth

By Jon Newton

investigations in the Human Responses Laboratory — believed to be the only one of its kind — into the Temposil-ethanol interaction. Other studies reconsider clinical uses of both drugs in the treatment of alcoholics and/or problem drinkers.

The conclusions ... years of work, ... examination ... two drugs ... disorder ... on.

'Facts don't bear out the Antabuse scare'

The articles in The Journal (Oct) by Jon Newton regarding Antabuse and Temposil are alarming to me, not because they seem to demonstrate new and hitherto unsuspected dangers from the use of the drugs but because I fear the heading and general tenor of the articles may induce a fear of using two drugs which have proved their worth, clinically, over many years.

I accept that Dr Peachy has done careful research but would have appreciated more specific data to indicate that the dangers of these drugs are, indeed, greater than those suggested by prudence and a reading of the earlier literature.

The occurrence of sudden death during an Antabuse reaction has been long known, as well as the incidence of psychosis and neuropathy. In over 25 years of extensive use of Antabuse, I have not, personally, encountered a death related to the Antabuse alcohol reaction and probably have seen one case each of psychosis, when the drug was improperly used, and one case of peripheral neuritis where Antabuse was only one of a number of suspect agents.

The advice in the article regarding physical examination and monitoring are commonly recognized good medical practices, but I wonder if there is any clear evidence that such routine procedures have actually prevented or aborted the onset of complications due to Antabuse since my impression is that such complications, especially the sudden deaths, have tended to occur in unexpected circumstances. In any case, much of the value in this drug lies in the patient having full knowledge and understanding of its use so the patient's collaboration is essential. Nor had I thought that any practitioner seriously using Antabuse would consider it the sole means of treatment for any individual suffering from alcoholism.

A further point to consider is that in dealing with any chronically disabling and frequently fatal disorder, which alcoholism certainly is, some risk is often attached to the agent being used in treatment. It seems apparent to me and, I think, to many others, that the risks, however real, in using Antabuse are miniscule compared to the risk of continuing alcoholism for most of its victims.

John D. Armstrong, MD, FRCP(C)
1333 Sheppard Ave E
Willowdale, Ont M2J 1V1

Alcohol has nothing to do with alcoholism?

Liquor industry is 'wolf in fold'

I read with great interest James Cowan's letter, Bartenders in excellent position to help, which was published in **The Journal** (Sept).

I feel compelled to comment as this is basically the same argument we are involved in throughout California and, indeed, in the United States.

I certainly don't feel we in the alcoholic field have cut the alcoholic beverage industry from our midst, but rather too often have welcomed the wolf into the fold to the detriment and watering-down of any meaningful alcoholism legislation or policies. Indeed, the National Council on Alcoholism, our lofty Queen, has taken this dangerous Prince Consort to bed and the results of that union have produced curiously bloodless and misshapen offspring (like Richard III — with crooked spines or no spines at all).

But let us consider it seriously. If it is true that approximately 13% of the population consumes 75% of all alcoholic beverages and are the most likely to encounter problems with alcohol — it is the ideal goal of those of us working in the field to get that 13% into programs that will result in abstinence. Is the liquor industry truly interested in helping us achieve that goal at the expense of 75% of their sales?

Even if they say: "Of course, we don't like problem drinkers any more than you do and what we're trying to create is a broader base of moderate drinkers" — well, how do you do that?

In their infinite wisdom, are they prepared to tell us when constitutes moderate drinking and who will or who won't become alcoholic? On the contrary, they tell us that alcohol has nothing to do with alcoholism and that people can be taught to use the drug "responsibly." If this is true, the only people who become alcoholic are "social misfits," "psychotics," and "moral degenerates," and if *this* is true, we are in the dark ages again, and how in hell do we expect people to seek help?

It is interesting and encouraging to note that Senator Donald Riegle's Subcommittee on Alcohol and Drug Abuse is currently not only holding hearings on the Warning Label issue, but also on "a staff report that raises the question of alcoholic beverage industry influence on alcoholism constituency groups and policy positions."

David E. Manley
Editor, The Eye Opener
Monterey County Alcoholism Services
Salinas, CA 93901

Can the liquor industry help create more moderate drinkers? Not likely, says letter writer David E. Manley.

Value for Thailand

The Office of the Narcotics Control Board here was set up about two years ago to act as both the central coordinating agency on all matters pertaining to narcotics control throughout Thailand, and the secretariat office of the Narcotics Control Board (NCB). This is chaired by His Excellency the Prime Minister of Thailand. Our work covers mainly four fields, namely, prevention, suppression, crop replacement and highland development, and treatment and rehabilitation.

Some copies of The Journal **have recently come to my hand and I have found them very helpful in our work. Therefore, I shall be very grateful to you if you will kindly put our office on the subscription list for this valuable publication.**

Police Major-General
Pow Sarasin
Secretary-General
Narcotics Control Board
Office of the Prime Minister
Sala Santitham, Bangkok 2
Thailand

Proper evaluation of Rxs for elderly urged

Further to the article: Drugs improperly prescribed to elderly (**The Journal**, July) we would suggest not all the conclusions drawn are necessarily accurate.

The writer, Betty Lou Lee, reporting on a paper presented by Dr W. Rosser at the 25th Anniversary Meeting of the College of Family Physicians, states that only short half-life benzodiazepines like oxazepam (SERAX®) should be used in elderly patients rather than long-acting compounds such as Valium®, Librium®, and Dalmane®.

This conclusion assumes that the pharmacokinetic measure known as serum (or plasma) elimination half-life should be the only criteria used in selecting a benzodiazepine for use in these patients.

Recent scientific investigation suggests, however, that short half-life benzodiazepines may precipitate rebound phenomena when average doses of these agents are used as anxiolytics and hypnotics for short periods of time, (Kales et al, 1979).

This new information also suggests that rebound withdrawal insomnia and rebound withdrawal anxiety may pose the additional problem of fostering potential drug abuse with these short-acting agents.

Perhaps what is needed in geriatric treatment is not a change from known and trusted agents to other compounds, based solely on half-life, but rather proper evaluation of the dosages and dose interval required in these patients.

It is for this reason that 'Valium,' 'Librium' and 'Dalmane' have each been formulated in different strengths, e.g. 'Valium' 2, 5 and 10 mg.

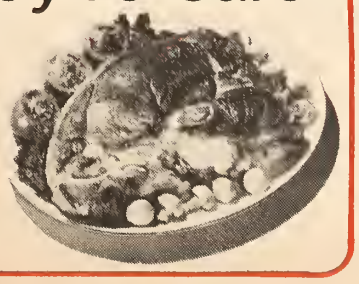
Arthur W. Montgomery
Manager, Professional Services
Pharmaceutical Division
Hoffman-La Roche Ltd
Vaudreuil, Quebec

Reference

Kales, A. et al, Rebound Insomnia — A Potential Hazard Following Withdrawal of Certain Benzodiazepines, *JAMA 241:* 16, 2692-2695, April 1979.

Sorry—they're safe

It has been drawn to our attention that those delicious-looking mushrooms pictured nestling against a steak (right), in The Journal **(Oct) are not, in fact, the inky cap variety and would not react with either Antabuse or Temposil.**



Letters to the Editor may be sent to: The Journal, 33 Russell Street, Toronto, Ontario, M5S 2S1.

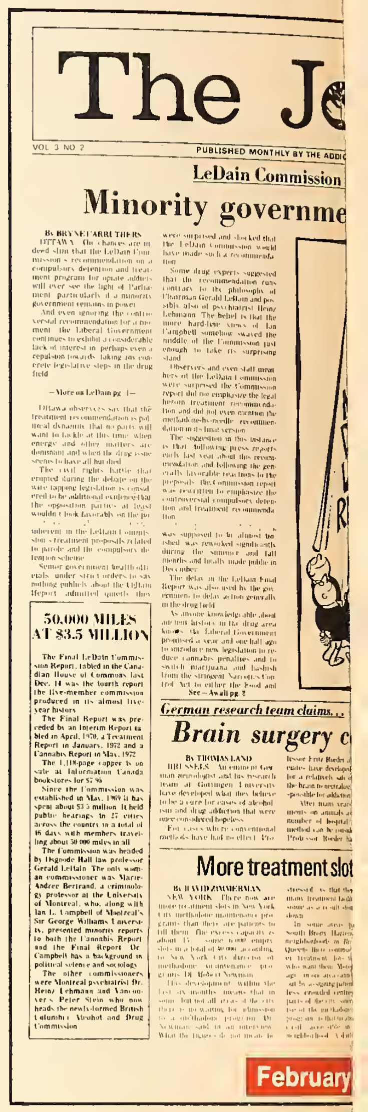
THE JO... in the S...

"Society ... has a great deal to gain from open discussion of the problems occasioned by the misuse of alcohol and other drugs." Upon that editorial note, The Journal of the Addiction Research Foundation of Ontario was started, in June 1972. Since then, that misuse has indeed been discussed each month in these pages. The Journal also has carried reports on important drug research findings, governments' moves and non moves in drug legislation, and trends in policies of drug agencies around the world — as reviewed here on some front pages from the Seventies . . .

OTTAWA--In a surprise development, Liberal, Conservative and . . . CHICAGO--Crimes committed by addicts t...

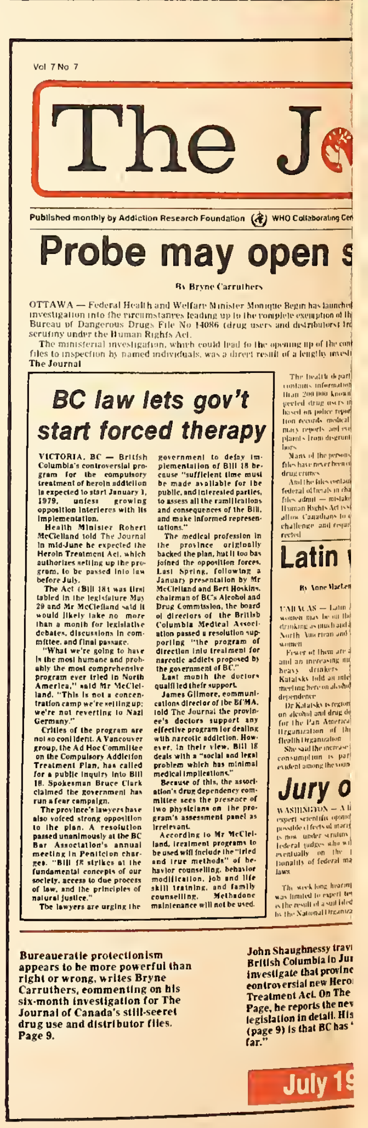

The Journal
VOL. 1 NO. 1 PUBLISHED MONTHLY BY THE ADDICTION RESEARCH FOUNDATION TORONTO, JUNE 1, 1972
ONTARIO HEALTH MINISTER WELCOMES A.R.F. JOURNAL
LeDain Treatment Report
Scholarship of lower level than Interim Report: A.R.F.
Canadian courts more lenient toward drug offenders in 1971
Marijuana Report
Nixon Commission stops short of legalization
June 1972


The Journal
VOL. 2 NO. 7 PUBLISHED MONTHLY BY THE ADDICTION RESEARCH FOUNDATION TORONTO, JULY 1, 1973
Inform public of dangers of alcohol misuse: CMA urges
SAODAP chief resigns after 'bitter struggle'
Government may be forced to bypass LeDain Report
Heroin epidemic can be beaten
Drinking in the U.S.S.R.
VODKA: life's greatest pleasure
July 1973


The Jo...
LeDain Commission
Minority governme...
50,000 MILES AT $3.5 MILLION
German research team claims...
Brain surgery c...
More treatment slot...
February...


Harlem drug Davids take on NY Goliath
The Journal
Vol. 5 No. 5 Published monthly by Addiction Research Foundation Toronto May 1 1976
Ontario grappling with teenage drinkers
Gov't plans 3-way hit on alcohol
Detox system has little impact: ARF study
Inside
Heroin: Catastrophic global implications
See page 5
May 1976


The Journal
Vol. 6 No. 1 Published monthly by Addiction Research Foundation Toronto January 1, 1977
US will plant scarlet poppies commercially
Heroin decriminalization investigation commences
Carter's interest high
Canada has reservations about new UN convention
NZ children win the right to drink in pubs
Backgrounder
1977 not 1877
Regular features
January 1977


Vol. 7 No. 7
The J...
Probe may open s...
BC law lets gov't start forced therapy
Latin...
Jury o...
Bureaucratic protectionism appears to be more powerful than right or wrong, writes Bryne Carruthers, commenting on his six-month investigation for The Journal of Canada's still-secret drug use and distributor files. Page 9.
John Shaughnessy traces British Columbia to Ju... investigate that province controversial new Hero... Treatment Act. On the... Page, he reports the ne... legislation in detail. His (page 9) is that BC has far."
July 19...

TORONTO--Female public drunkenness can be treated as a public . . . HONOLULU--Low incidence of alcoholism...

Special Inside!

CALENDAR FOR 1980

by Hardley Jones

for

The Journal

1980

ADDICTION RESEARCH FOUNDATION OF ONTARIO

SEE Y'ALL IN WASHINGTON!

TWO FULL MOONS IN FEBRUARY

ME TOO!

ST. SWITHINS JULY

GROUNDHAWG DAY / JAN (or FEB)

Hey, man! Like this is a joint conference

NDC NDAC ADPA ERENCE

JOINT CONFERENCE WASHINGTON/SEPT

L'Eglise Notre Dame? Le Seminaire Des Sulpiciens? Toe Blake's Tavern?

CANADIAN ADDICTIONS FOUNDATION/MONTREAL AUG

SUN ENTERS ARIES/ SPRING

HIC!

NETHERLANDS/AUG CONFERENCE APEUTIC ities

No pot!

NO-But care to drop some acid?

Gee, Tex! When you asked me to join you in a martini...

15th AHHAP TEXAS/JUNE

JAN

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6	7	8	9	10	11	12
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27	28	29	30	31		

FEB

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MAR

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APR

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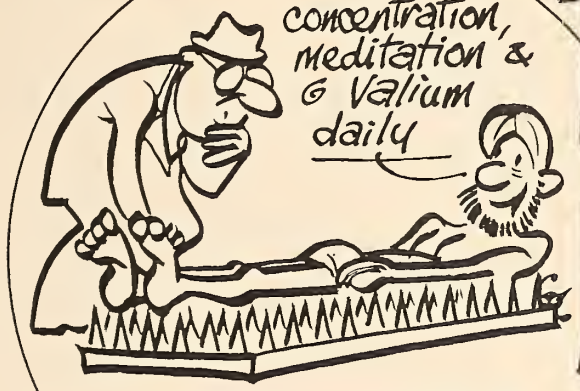
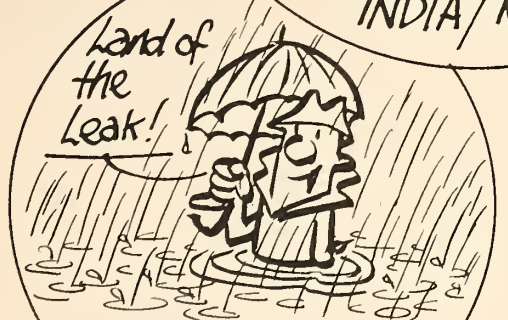
INTERNATIONAL CONFERENCE ON ALCOHOL, DRUGS & TRAFFIC SAFETY SWEDEN/JUNE

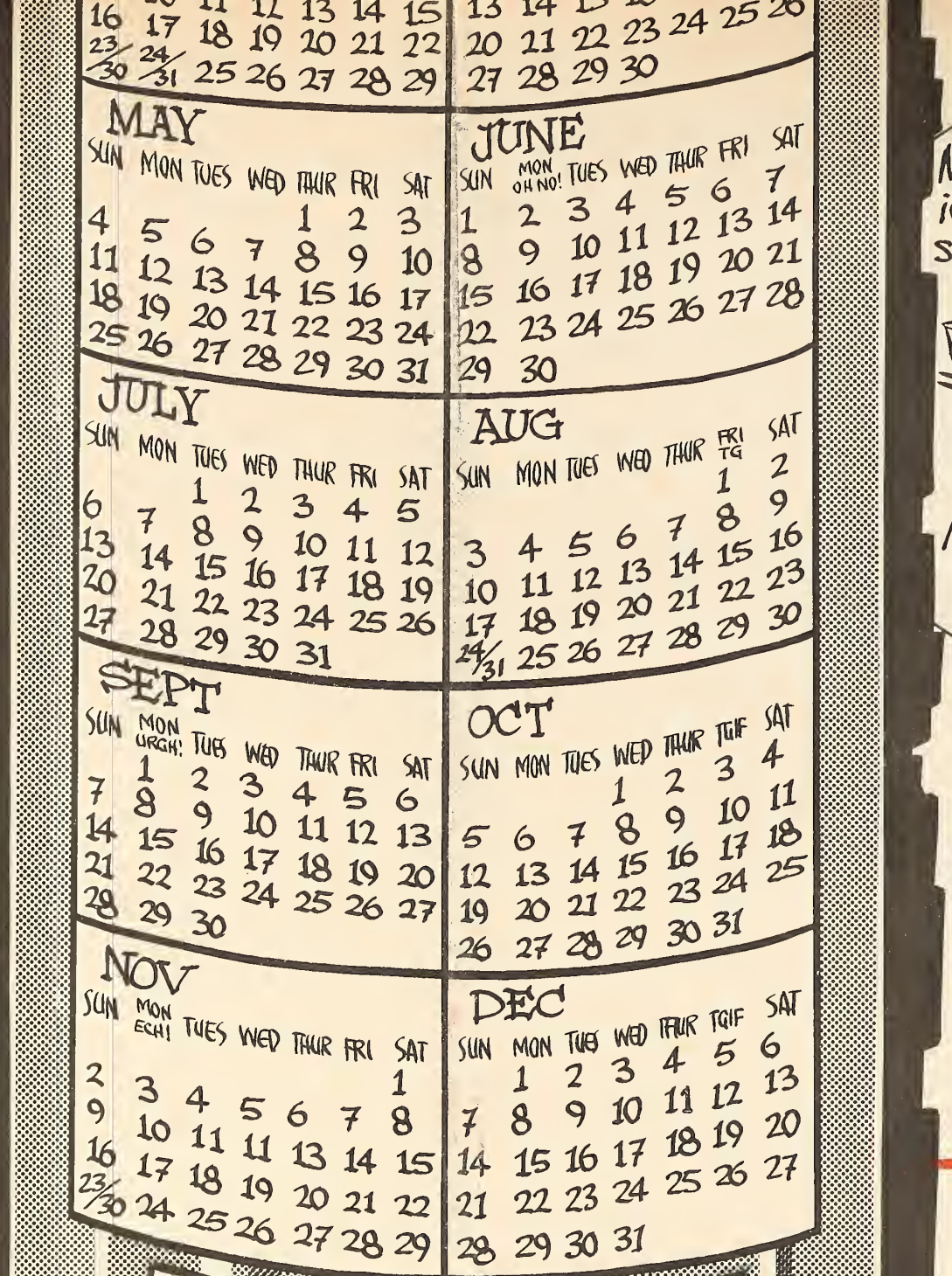


NATIONAL & REGIONAL WORKSHOP ON DRUG ABUSE INDIA/MARCH



26th IIPTA WALES/JUNE

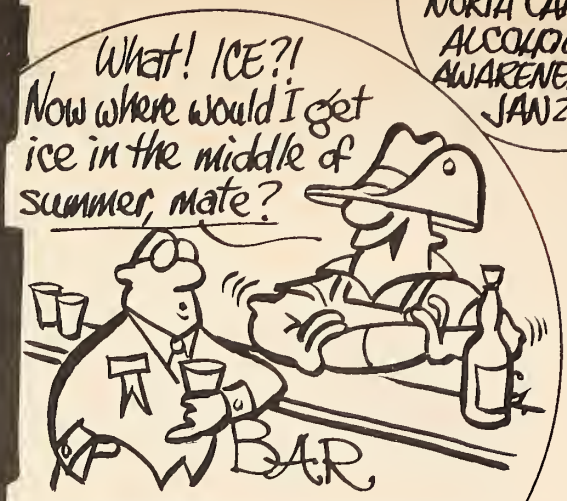
HIC! NCA SEATTLE HIC! MAY



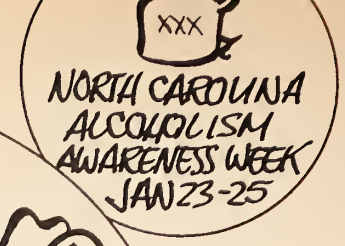
WARNING!

The Journal

BECOMES HIGHLY ADDICTIVE WHEN TAKEN REGULARLY

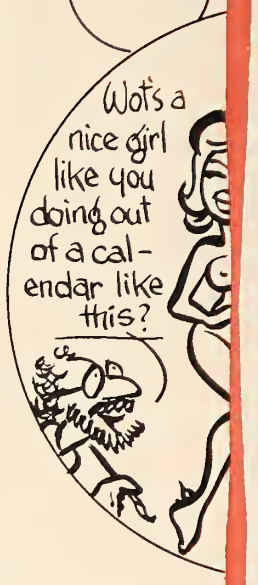


1ST PAN-PACIFIC CONFERENCE ON ALCOHOLISM & DRUG DEPENDENCE AUSTRALIA/MARCH



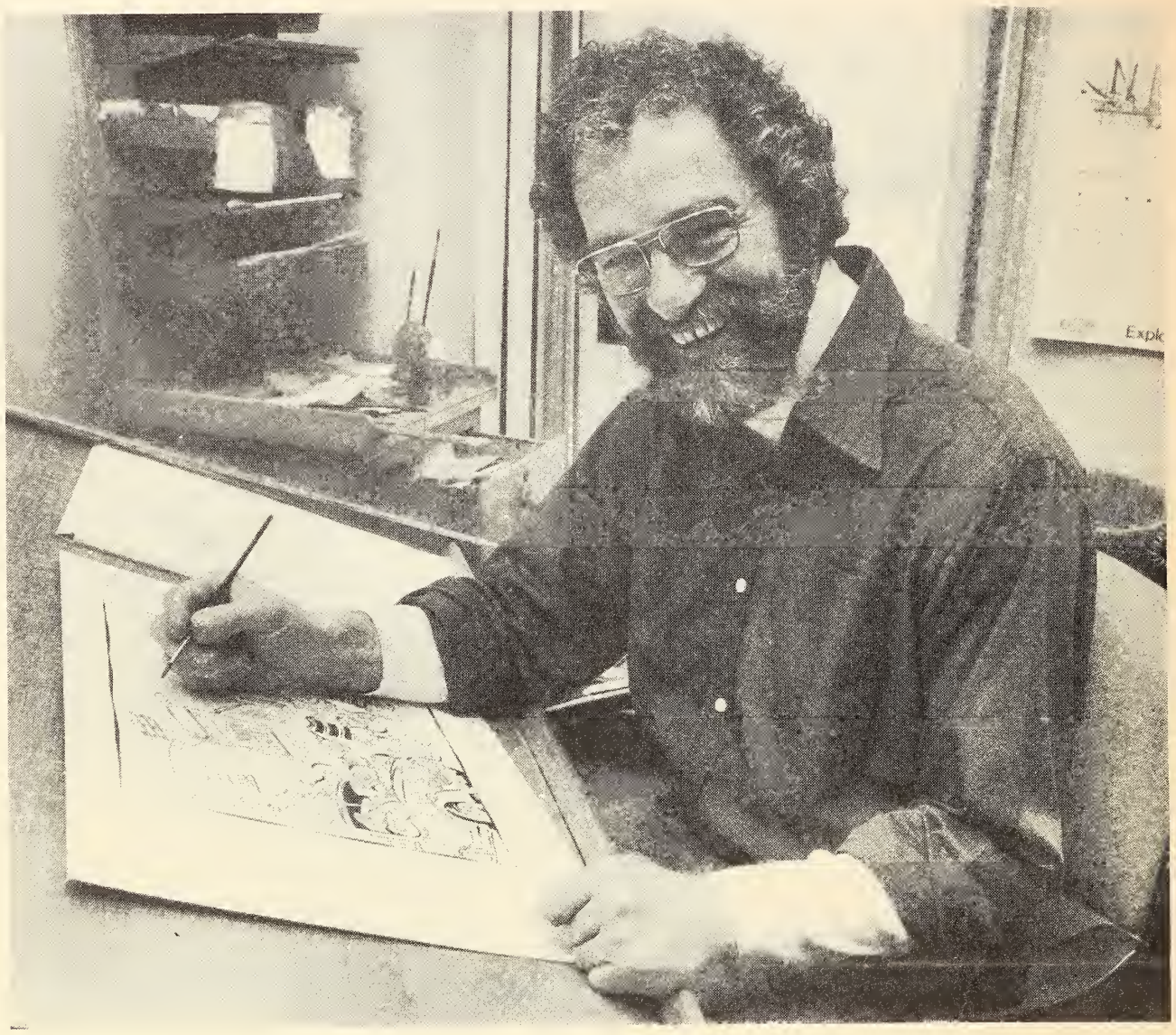
NORTH CAROLINA ALCOHOLISM AWARENESS WEEK JAN 23-25

930 IN NEWFOUNDLAND



NEW FRONTIERS IN ADDICTIVE BEHAVIORS ALASKA/JUNE

About the artist



Yardley Jones, The Journal's **popular editorial cartoonist, lives and works in Montreal. Formerly cartoonist for the now defunct** Montreal Star, **Yardley's cartoons and carricatures continue to be syndicated in newspapers coast to coast. Yardley is branching out into design work for national daily ads and trade books, while, of course, continuing to delight our readers with his exclusive monthly cartoons for** The Journal. **When the work slows down, he says, he can be found at the corner of Peel & St. Catherine Sts., selling pencils.**

Additional Copies

For information on reprints of The 1980 Calendar, and prices, please write Marketing, Department 732, **The Journal**, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Canada, M5S 2S1.

URNAL
eventies

A Seventies wrap-up
The Back Page

support their habit threaten . . . LONDON--Clinicians are cautiously optimistic about the hard . . .

urnal
RESEARCH FOUNDATION TORONTO FEBRUARY 1, 1974

es final report
slow to budge

cure 'hopeless cases'

Kassel-based Academy of Criminological Research

He went on: "Our research has revealed that dependence on drugs of alcohol assumes the proportions of a natural urge after a certain period and like the sexual drive or the urge to eat is controlled by a certain brain centre. Neutralizing this centre which is

an patients

community facilities without totally motivated done would defeat the program's purpose," Dr Newman said.

The added that programs are different from one to today and provide varying services according to the daily methadone — that patients a month for a relatively short period from one to the other. In addition to the roughly 11,000 patients in methadone maintenance at the start of the year, Dr. Newman said that 20,000 New Yorkers are in drug free programs. He declined to speculate as to what percentage of the addict population in the city now is in one or the other kind of treatment.

74

The Journal
VOL 4 NO 7 PUBLISHED MONTHLY BY THE ADDICTION RESEARCH FOUNDATION TORONTO JULY 1, 1975

Major pot law changes ahead

OTTAWA After four months of public hearings, the Senate Committee on Legal and Constitutional Affairs has recommended a number of significant changes to the federal government's cannabis bill, including an amendment to eliminate, in effect, the controversial "reverse onus" for people accused of cannabis possession for the purposes of trafficking.

As important, the Committee has recommended an automatic pardon be granted all persons found guilty of a first offence of simple cannabis possession and then given an absolute or conditional discharge in place of a formal conviction.

Stiffer maximum penalties for those convicted by way of indictment for trafficking cannabis or possessing it for the purposes of trafficking are recommended. 14 years less a day in jail instead of 10 years.

And the maximum penalty for importing or exporting cannabis would be modified slightly from 14 years in jail to 14 years minus a day.

By using the 14 years less a day maximum penalty, even people convicted of the most serious cannabis crimes would still be eligible for absolute or conditional discharges under appropriate circumstances — such as when the trafficking or importing is shown to be done by amateurs as opposed to hardened criminals or profiteers for the money exclusively.

In another important amend

More from Ottawa — page 2

ment the Senate committee recommends elimination of the minimum three-year jail sentence for importing. To give judges more flexibility in sentencing and also to permit use of the discharge provisions. Under the bill proposed by the government the three-year minimum sentence would be waived only when an individual could prove to the court that the importing was for personal use only.

The virtual elimination of the "reverse onus" principle for people charged with possession of cannabis for the purpose of trafficking would be accomplished this way.

Instead of forcing the accused who is found guilty first of possession to prove he or she was not intending to traffic the drug, but rather had the cannabis for personal use, the amendment would give the accused and the prosecutor equal chances to prove their own case.

That is the accused would first be given a chance to argue there was no intent to traffic the drug and therefore the charge should be reduced to simple possession, with less severe penalties.

Then the prosecutor would be given a chance to adduce evidence to establish that the accused was in possession of the controlled drug for the purpose of trafficking.

The change which would have cannabis treated as all other controlled drugs in this respect

See — Major — page 31

NIAAA director steps down

WASHINGTON—Dr Morris Chalefz, the first director of the US National Institute of Alcohol Abuse and Alcoholism (NIAAA), has resigned effective September 1, the fifth anniversary of his joining the government.

Dr Chalefz said the reason for his departure is a promise to his wife that he would not stay in government for more than five years.

I tried to leave in April of last year after the second Report on Alcohol and Health had been completed he said But he indicated

DEA chief fired . . . page 3

he was prevailed upon to stay.

However he said I did promise my wife I would leave at the end of the five-year period and I think promises like that have to be kept.

Despite Dr Chalefz's explanation, rumors persist that his resignation is, at least in part, related to increasing pressure from his opponents.

Observers agree that Dr Chalefz, an outspoken advocate of "responsible drinking", stood on many a bureaucratic toe during his five years in office.

In a June 9 letter to Health, Education and Welfare (HEW) Secretary Casper Weinberger, Dr Chalefz said he was announcing his resignation now to allow a careful search for my successor and to permit an orderly transfer of my responsibilities".

Concerning his successor, Dr Chalefz said whoever it is I sure hope it's a strong person. I think there are all kinds of challenges facing us and I'd like nothing more than to see someone who can take over and go beyond what

Dr Chalefz

I think has been a remarkable accomplishment of the NIAAA.

The Alcohol and Drug Problems Association of North America (ADPA), based in Washington, moved quickly to launch the search for an appropriate successor.

In a letter to its 3 600 members, ADPA President R Leonard Poche encouraged individuals to pass along their opinions to ADPA

(See — Chalefz — page 2)

Native children sniffing gasoline

By MANFRED JAGER

WINNIPEG—Getting high on gasoline fumes has become a major problem among native children in isolated northern Manitoba communities.

Blood samples taken from 50 Shamattawa children aged six to 15 years recently showed that all suffered from an enzyme-lowering form of lead poisoning.

Shamattawa is a small Indian village about 200 miles northeast of Thompson accessible only by aircraft.

The situation there was described by one of the researchers, Dr Robert Fosiakowsky a paediatric resident at Winnipeg's Health Sciences Centre as "probably typical of such communities throughout the north".

His opinion was backed up by Dr Harold Roth of the medical services branch in the federal department of health and welfare in Thompson.

Dr Roth said gasoline sniffing among native children is "much more prevalent" than had been thought.

"Maybe it all isn't just happening now" he said "Maybe we just weren't aware of it.

Lately we have become very aware. I can tell you that Shamattawa certainly isn't an isolated situation"

It is retroethyl lead—the organic lead content in gasoline—that makes it particularly dangerous as an inhalant

Simply put said Dr Fosiakowsky children

(See — Children — page 3)

While many tighten laws

BC goes easier on alcohol

By PETER THOMPSON

VANCOUVER—The chairman of British Columbia's Alcohol and Drug Commission applauds the province's new liberalized liquor laws.

Commission chairman J Peter Stein said the new laws would have little effect on the rate of alcoholism or problem drinking.

"I just don't believe that the laws by increasing access to alcohol will increase significantly the rate of alcoholism in the province" Mr Stein said.

"The effect of the laws will be to make it easier for responsible drinkers to get alcohol."

Mr Stein said the legislation might mean fewer car accidents as a result of impaired driving.

Mr Stein's support of the new legislation stands in direct contrast to the positions of several other provincial agencies—most notably the Addiction Research Foundation of Ontario. ARF scientists have demonstrated a direct link between rising alcohol consumption and the rate of alcohol problems and believe further liberalization of liquor laws is a sure-fire way of increasing total consumption.

As in most if not all provinces liquor in BC is sold through government stores most of which close early in the evening. Anyone wanting to buy beer in the evening is faced with driving either to one of the few government stores that are open, or more likely to one of the province's beer parlors. The beer parlors are huge and often located at great distances from each other and the people who use them.

Walking to a corner store for more beer would be less hazardous than driving to a beer parlor if the person has already been drinking Mr Stein said.

Mr Stein said research done by Robin Room of the University of California at Palo Alto, concludes that easier access to alcohol does not have a significant relationship to an increase in alcoholism.

He said Dr Room's work also indicates increased prices have little effect on the problem drinker. He just spends more of the money available to him on alcohol. Mr Stein said.

Changes in BC's comparatively restrictive liquor laws were introduced shortly after the New Dem-

(See — Alcohol — page 2)

FADS GO EASTWARD

MUNICH—A recent report by Bavarian narcotics and addiction experts seems to prove a point observers of international societal behavior have been making for a long time.

Fads and fashions as well as patterns of crime and addiction, seem to have a distinct eastward bent in the mid-20th century.

The majority originate in North America then envelope Western and ultimately Eastern Europe.

This seems to be as true of tastes in clothing and music as it is in drug and alcohol usage.

According to a Bavarian state government report issued in early June, drug usage among juveniles here decreased markedly last year while alcohol consumption went up sharply.

The peak of interest in and curiosity about drugs among youths has been reached the report said "Instead attention is now focused on alcohol, especially among the younger age groups.

Although the number of addicts under treatment in state and municipal hospitals is still on the rise Bavarian authorities expect this to decrease this year and next along with diminishing interest in drugs.

The report did stress however, that drug-related fatalities as well as cases of serious addiction are on the increase.

Every fourth patient being treated in Bavarian psychiatric hospitals at present is a narcotics addict.

Pot smoking pilots - Page 5

INSIDE . . .

Addicts turn to cough syrup -Page 3
Inpatient family therapy -Page 4
Baking way to recovery -Page 6
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The Narconon Story Part 2 -Page 16

July 1975

The Journal
VOL 5 No. 3 PUBLISHED MONTHLY BY ADDICTION RESEARCH FOUNDATION TORONTO March 1, 1976

This is what happens if you smoke when you're pregnant.

Every time you inhale you fill your lungs with nicotine and carbon monoxide.

Your blood carries these impurities through the umbilical cord and into your baby's bloodstream

Smoking can restrict your baby's normal growth inside the womb

It can make him underdeveloped and underweight at birth.

Which, in turn can make him vulnerable to illness in the first delicate weeks of his life.

h can even kill him.

In just one year, in Britain alone, over 1,500 babies might not have died if their mothers had given up smoking when they were pregnant.

If you give up smoking when you're pregnant your baby will be as healthy as if you'd never smoked.

Is it fair to force your baby to smoke cigarettes?

Britain's Health Education Council is continuing its campaign against tobacco with multi-media publicity that shows smoking not only as a health hazard but also anti-social, ugly and expensive
Complete story on page 2

Pot decriminalization

It's inevitable say experts

By Anne MacLennan

NEW YORK CITY — Cannabis will be decriminalized throughout the United States and sold — perhaps through government outlets — within the next four or five years.

The predictions came at the end of what some people called "the last of the big cannabis meetings". And when they came, they seemed both the inevitable result of the three-day scientific meeting and yet something quite apart from it.

Inevitable because scientist after scientist, many of them researchers on one of the three major series of studies of chronic cannabis users — in Jamaica, in Greece and in Costa Rica — acquitted cannabis of causing dramatically deleterious effects.

Apart from it because already, and outwardly, neither despite science nor because of it, the move towards decriminalization has gathered enough momentum to take it at least across the United States.

Michael Sonnenreich, a Washington lawyer who has been involved in critical review of much of the US cannabis legislation and who was director of the National Commission on Marijuana and Drug Abuse, was one of the speakers at the final session of the meeting — Social Policy and Marijuana Use.

"Whether marijuana is more harmful than we at present surmise, or less harmful, is a question of degree not a question of new revelation.

"My own feeling about the social change with respect to marijuana is that change is inevitable. It's a question of time.

"When California went, [decriminalized] 10% of the population of the United States went with it . . . The reality is you're going to see another state go and another state. The federal law will change when we've got about 30 or 35 states.

"People have to be aware of the fact we are in transition and I don't think there's any question about it. The transition is occurring. The degree of transition and the speed of transition can be held up by a variety of factors. But, I don't think it's going to stop.

"I think the momentum is there and all's going to carry — whether cannabis use carries civil fines and everybody for-

(See — 29 million — page 5)

Dr DuPont plays down cannabis threat

WASHINGTON — In his first public comparison of marijuana with alcohol and tobacco, the head of the National Institute on Drug Abuse maintains the two popular "recreational" drugs cause far greater health problems than does marijuana.

Marijuana, said Dr Robert DuPont, lacks the lethal effects of either alcohol or tobacco.

At a press conference where he released new research on marijuana and health report, Dr DuPont held that civil penalties should be substituted for criminal prosecution for possession of marijuana.

Personally, no news is that we do not have to threaten young people with imprisonment to discourage the use of marijuana," he declared. (In recent months, several states

(See — Ford — Page 3)

A 'galloping consumption'

Canadians wolfing down pills

By Milan Korcok

HAMILTON — A McMaster University study has revealed a "galloping consumption" of medical drug use among Canadians, and has warned that physician-induced drug abuse may be emerging as "a socially significant phenomenon".

The study, prepared by the university's department of clinical epidemiology and biostatistics, under the direction of Dr Abraham Chaitan and Dr Walter O Spitzer notes that 60% of the people studied had taken at least one medicine in the 48-hours prior to interview, and 30% had taken at least one drug prescribed or suggested by a doctor.

The McMaster study, published in the Canadian Medical Association Journal (January 10), was based on interview surveys of 20% of the households in Smithville, a rural and residential Ontario municipality, and a random sample of families receiving their primary medical care from a suburban family practice in Burlington, Ontario.

To minimize the chance of error in subject recall, questions concerning drug use were limited to use within the previous 48 hours.

The questions related to pain relievers, cough and cold remedies, laxatives and stomach remedies, vitamins and tonics, sleeping pills, tranquilizers and sedatives, oral contraceptives, antibiotics, and medicine for the heart and blood pressure.

Data revealed approximately 36% of the people interviewed had taken at least one non-prescription drug in the previous 48 hours, 25% had taken two, and 20% three or more.

In terms of prescribed medications, 36% of the respondents in the Smithville community surveys had taken at least one drug in the past 48 hours, as had 29% of those in the family practice survey.

The most frequently-used prescribed drugs were tranquilizers, and antibiotics.

Among people 20 years and more 8.8% of those in the community survey, and 10.5% in the practice survey, reported using tranquilizers in the 48 hours prior to questioning.

Use of these drugs was twice as prevalent among females as males, and more than 50% of sedative and tranquilizer users were 50 years and older.

The report notes that oral contraceptives were used by close to 15% of the respondents in the Smithville survey, and 17% in the practice survey.

Antibiotics accounted for only 1.7% of prescribed drug use in the community survey and 2.4% in the practice survey.

(See — Canadians — Page 2)

BC chief named

VANCOUVER (C) — The Journal learned at press time that Herbert Hoskin, former director of the British Columbia Narcotics Addiction Foundation, has been appointed acting head of the Alcohol and Drug Commission here.

He replaces Peter Stein who, along with the five other commissioners, was fired in January by the new Social Credit government.

The commission will be reorganized, with three commissioners instead of six, and an Advisory Committee comprising civil service representatives from the departments of health, education, finance, human resources, and the Attorney General, and from professionals involved in drug treatment. The commission offices have been moved from Victoria to Vancouver.

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TORONTO July 1 1978
urnal
esearch and Training on Alcohol and Drug Dependence Problems

cret drug files

Monique Begin has launched a special investigation into Canada's secret drug files

As a result of a special cabinet order approved earlier this year [illegible] is free the privacy provisions of the Human Rights Act came into force Canadians named in the files cannot even find out whether their files exist let alone whether the information con-

omen take to liquor

educated and middle and upper class women

It's the first time we have data which indicate some change may be taking place in the drinking patterns of Latin American women she said

She cautioned that no longitudinal data are available and the suggestion of a change is based on drinking differences in different age groups It was in the 25 to 34 year old age group that drinking was most pronounced

If the change proves to be real she said certainly it could be seen in terms of changing roles for women and of their increasing liberation

The information came in the first multi-national study of drinking patterns in Latin America Five cities were surveyed — San Paulo Brazil, Sao Jose Costa Rica and Santo Domingo

Although men are still much more likely to drink and to drink heavily than women in Kalafeks said the study unexpectedly suggested that increased drinking by both sexes in Latin America requires more attention

Like their North American counterparts Latin Americans favor hard liquor as their first choice with beer in second place This differs from North Americans in that they drink less frequently and get drunk less often said Dr Kalafeks

The study was carried out under a grant from the United States National Institute on Alcoholism and Alcohol Abuse

t on US pot laws

the Reform of Marijuana Laws (NORML)

NORML claims that the present laws are a violation of the rights of privacy and criminal penalties for private possession of the drug are a cruel and unusual punishment and denial of equal protection of the law.

The hearing was held before Judge Aubrey Robinson who will now confer with other judges to decide a final ruling. The losing party NORML or the US government has right of direct appeal to the Supreme Court.

Judge Robinson said at the end of the hearing he had been extremely impressed with the witnesses on both sides. We are not finished in being able to assemble these kinds of experts for what is an extremely difficult problem.

Nadelmann in the judge's expected to be over with

The coffee which gets most North Americans started in the morning may soon have a special attraction for athletes in endurance sports. Page 2.

Officials in Manitoba and The Yukon have expressed grave misgivings about the effect BC's new legislation may have on other provinces. Page 3.

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The Journal
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Drug policy changes slated for spring?

By Jeff Carruthers

OTTAWA — Federal Health Minister Monique Begin and Justice Minister Marc Lalonde are working up a package of major drug policy changes that will likely be announced early in 1979 just before the spring federal election.

Under consideration as the long-awaited relaxation of penalties for cannabis possession crimes as well as an unexpected proposal to transfer away from the health department certain administrative powers assocated with drug crimes.

Ms Begin told The Journal that "certain police powers do not properly belong within the health department and should be transferred to a more appropriate agency.

Reference was made to the powers given the health minister relating to the seizure and disposition of automobiles, boats, and aircraft believed to have been used for drug crimes.

Under certain instances, the Narcotic Control Act makes the health minister responsible for deciding, for example, whether seized vehicles, planes, and other items connected with drug crimes should be kept by the government or returned to their rightful owners.

Often, it is unclear whether the property was in fact used in connection with a crime and who owns it.

It has been recognized for a long time within the department that, in many instances, neither the health minister nor the health department has the resources in the best position to decide. Most often it is the court that heard the trial involving a conviction that is best able to determine, for example, whether an aircraft used in a crime really belongs to someone who was unconnected with the crime but unwittingly lent or rented the vehicle for use in a crime.

With this in mind, legislative changes could either transfer the responsibility to the justice department or the judiciary.

Curiously enough, the requirement to rather immediately for deciding disposition of seized goods was a key rationale offered by the health department for the keeping of detailed personal files on known and suspected drug users in Canada — files that, until recently, had been kept secret

The Journal. (See 1978 f

Other changes under consideration include modifying the powers of search and seizure now given drug squad members and customs officers involved in drug investigations especially those relating to search of private property without a court issued warrant.

At present, designated members of the RCMP may use blanket warrants called "writs of assistance" to enter any house in search of narcotics, and judges may issue search warrants based solely on evidence from a police officer that he or she believes narcotics might be present in a particular location.

While the power to issue writs of assistance has already been transferred from the health minister to the justice minister in drug cases, further changes are being contemplated to limit both the number and duration of those issued, and perhaps even limit their scope.

Begin blasts BC plan

VANCOUVER — Federal health minister Monique Begin tangled with the British Columbia compulsory heroin plan on a radio talk show here, emerging bloodied but unshaken in her opposition.

"It will be like prison; it will be custodial more than anything else," she said of the plan, which was set to come into effect Jan 1.

"Compulsion has never worked in the treatment of addiction. It is my viewpoint as minister of health, if people aren't motivated it won't work".

But when Ms Begin rang off, two top figures in the BC plan fell into her in response.

Bert Hoskin, chairman of the BC Alcohol and Drug Commission, called her "one of the most ill-advised, ill-informed ministers in the history of drug dependence".

"As long as the problem is this side of the Rockies, they couldn't give a damn".

Contradicting statements by Ms Begin, he said compulsory treatment has worked, the province is providing other facilities than the 150-bed detention unit, and medical treatment staff have been hired.

He also quoted over figures. The province has asked federal government for $2.4 million in startup costs and $8.4 million a year, not $18 million, he said.

The federal government has said it will give the program nothing at all. Provincial health minister Bob Mc[illegible] failed again to get any support when he attempted to see the federal minister in Ottawa shortly after the radio program.

Provincial Indian Chief Joe Rosher, on leave to serve as local counsel for the heroin program, joined Mr Hoskin in condemning Ms Begin.

"I'm stunned. I can't believe she's that ignorant and cutting corners

It's the Year of the Child

[illegible] said the world United Nations meeting position to Renew the concern for children — as we most [illegible] and cutting corners

Puzzle of paraquat: 'Nobody knows'

WASHINGTON — Many who feared that paraquat contaminated marijuana would cause lung damage have now swung to the belief that the herbicide is destroyed during smoking. Problem is — nobody knows which.

This is the experience of Harold Smith, medical director of the Haight-Ashbury Free Medical Clinic following the panic when it was reported marijuana contaminated with the herbicide was reaching the United States from Mexico.

Dr Smith said his clinic was inundated with calls after the story appeared and "there was a severe psychological panic with agitation and depression and the feeling by a lot of people that they were being poisoned.

Dr and Mrs Galbraith hypothesized that paraquat is destroyed during smoking.

Dr Smith said that during the height of the scare "we ran approximately 30 individuals who came in with respiratory distress. Some were non-smokers and some were [illegible] burning in the back of the throat.

We found that none of the patients had pulmonary lung deficiency.

Dr Smith, in a report to the annual meeting of the National Organization for the Reform of Marijuana Laws (NORML) said an exploratory study was made of a 12 year old male who had a classic clinical picture for paraquat inhalation (respirators approximately 30 individuals who came in with respiratory distress. Some were non-smokers and some were [illegible] burning in the back of the throat.

However his pulmonary function was found to be completely normal, he added.

Dr Smith said he felt the irritation was caused by heavily marijuana use and his condition was exacerbated by the paraquat panic.

We could have said that definitively if we had known for sure there was paraquat on his marijuana but we didn't.

Dr Smith is worth of that those who first heard fears of damage from paraquat now believe there is nothing to worry about because smoking destroys it.

We don't know

Inside The Journal

• David Smith on Valium study Page 7
• Where we're at... where we're going The Back Page

January 1979

Political winds shift on pot decrim

By Jeff Carruthers

OTTAWA — In a surprise development, Liberal, Conservative, and New Democratic spokesmen have agreed that speedy House of Commons passage be given legislation to eliminate the criminal aspects of simple marijuana possession in Canada.

So far, however, nothing more has happened to give Canadians who are interested in seeing marijuana crimes no longer result in jail terms or criminal records the hope they had been reaching for.

Only the tiny Social Credit Party has said it is unwilling to have a decriminalization bill go through Parliament quickly.

Nevertheless, the political winds seem to be shifting noticeably in the shadow of the upcoming federal election. Contrary to Liberal party insider views that marijuana is an issue to stay away from both the opposition Conservatives and the New Democrats now seem interested in getting the drug issue straightened around, and fast.

Behind the most recent concern is the feeling that too many young Canadians are being saddled with criminal records after being caught with the cannabis plant when it's a first offence. Both sides of the House believe cannabis should still be illegal and that greater efforts and more severe penalties should be aimed at traffickers and importers.

The recent political accord emerged as a result of a question in the Commons by Conservative youth critic Paul Dick, who criticized the government's failure to deal with the cannabis issue as promised almost seven years ago.

(See — Lalonde — page 2)

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Some silver in the lining

US drug agencies face cuts

By Harvey McConnell

WASHINGTON — Alcohol and drug agencies in the United States face a direct 10% cut in federal funds for the next fiscal year and a possible new system of doling out the moneys which could cripple their services even more.

One of the proposals in US President Jimmy Carter's 1980 budget is to switch the present system of categorical formula grants to block grants. This switch would cover not only alcohol and drug but mental health programs as well.

Instead of funding being channeled through the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA) and the National Institute for Mental Health (NIMH), the moneys would go into a general pot with each state government determining how much is given to each agency.

Officials in the drug and alcohol field say mental health is now a clamor room following the report of the Presidential commission on Mental Health and many members of the public still consider drug abuse illegal and alcohol abuse immoral.

There is some silver in the lining. Research money for NIAAA will go up from $22 million to $25 million and for NIDA from $46 million to $50 million. Research for mental health will zoom up from $133 million to $160 million.

Although NIDA gets an extra $2 million for research this will now have to include investigations into smoking which is now under the institute's aegis. Some of the cuts in funds will be for NIDA and NIAAA funded training programs for workers in the field.

The cut in the budget to $100 million for all three agencies is not unexpected. Presidential spokespersons say this is all part of the national health program.

One legislator who has said he

Carter hits trafficking

WASHINGTON — The United States expects even more cooperation from foreign governments in fighting drug trafficking, according to President Jimmy Carter.

In his State of the Union message to Congress, President Carter said this year emphasis will be put on behavior of people who turn to drugs and [illegible] will stress financial investigations as a means of prosecuting those individuals responsible for the drug traffic, and will rely heavily on enlisting foreign cooperation in the overall drug program.

"These efforts should further our success in controlling drug abuse both in the United States and abroad."

He added "seizures of illegal drugs are at their highest level ever. Improved coordination and cooperation among federal agencies have resulted in a more effective drug program without major budget increases."

BC plan illegal, delegates charge

By Tim Padmore

VANCOUVER — Delegates to an international symposium on the female offender here have called on the British Columbia government to repeal legislation providing for compulsory treatment of narcotics addicts.

An overflow plenary session voted 60 to 6 in favor of the repeal resolution. There were close to 500 registrants.

The resolution says compulsory programs like the one now in effect in BC are illegal measures of civil rights and undermine voluntary programs. It asks that the money allocated for the compulsory plan be used for voluntary programs that show genuine respect for the personal liberty and personal needs of drug users.

A substantial number of delegates abstained from the vote — 30 in all. One abstainer explained that as a civil servant he felt he could not directly challenge the BC government although he would like to vote in favor.

The motion reached the floor only after a struggle with symposium organizers who argued

[illegible] The Journal [illegible]

[illegible] that there was no space in the program for presentation of resolutions.

Conference co-chairman C T Griffiths, a Simon Fraser University criminologist told The Journal emphatically that the vote was unofficial and represented the opinion of only a minority of conference participants.

Marie-Andree Bertrand head of the group that put forward the heroin resolution, along with a number of others dealing with women and crime, said the delegates were anxious to show there is support from outside the province for those opposing the plan.

Dr Bertrand a University of Montreal criminologist and former Leftist reform volunteer said it was only an hour before hand that the group learned this would be allowed to present its resolutions.

Also passed by near unanimous votes were motions urging decriminalization of all forms of drug use and calling on both levels of government to promote community drug treatment facilities to supplement in effective prison programs and to assist released inmates into them

INSIDE

March Quote
Marshall McLuhan exclusive interview Pages 4, 5
'Slow-motion suicide' US Surgeon General's Report on cigarette smoking Pages 8, 9

Drinking drivers TV stars

VANCOUVER — Drinking drivers in parts of British Columbia now face the embarrassment of seeing their drunken antics replayed on television in court.

Police in Vernon started the camera rolling and succeeded in convincing a provincial court judge to accept in evidence videotaped recordings of the accused's behavior when charged.

In February, police in the town of Quesnel announced they too would begin using the video recorders.

Val Bottiger, Page the TV displays will boost the conviction rate, convince more drunk drivers to plead guilty, and most optimistically discourage others from drinking and driving in the first place

March 1979

among orientals has often . . . NEW YORK--Vigorous law enforcement efforts against illegal drug . . .

NEWS

Phases of dependence in youth

HAMILTON — A four-phase evaluation technique to assess drug dependency in teenagers is being used by a Minnesota centre.

"Adolescents are hard to evaluate," says Pat Griffin, director of the chemical dependency division of Washington County Human Services in Woodbury. "I can sit with a middle-aged alcoholic and tell if he's alcoholic in 45 minutes, and what he needs, besides AA (Alcoholics Anonymous). But teenagers, where there's no history to go by — it takes him an hour to say hello, and you can't believe a word he says."

Mr Griffin was speaking at the annual Institute on Addiction Studies here.

The process is an eight-week out-patient one and involves youth whose behavior has already put them in some jeopardy. They are referred by police, judges, probation officers, parents, or schools.

Mr Griffin noted characteristics of each phase.

Phase one is considered a learning phase. Of any five youngsters who first try alcohol or another drug, one will get sick, one will decide it did nothing for him, and a third will decide "It's not worth the risk to screw around with it because there's not that much to it," Mr Griffin said. The fourth will think it's good, and he's going to look into it, but the fifth will think, "Super, the greatest thing since canned beer.

"He's in trouble from the first instant."

Phase two brings a negative dimension to the high, intoxication, or euphoria that comes with use. It's followed by a downer, a hangover, or depression that is painful. But after three to 10 hours, he will return to the normal range of up and down daily emotions.

Mood swing

In this phase, "getting high" moves up in his list of values, such as home, school, sports, and hobbies, and may start to displace one or more in his priority system.

He starts to associate more with users and to be preoccupied with "Friday night when they do their thing." It now takes more of the chemical to do the same job because he's developing tolerance, and he's having mood swings and personality changes.

"He becomes sullen and silent, and figures the best defence is to shut up and say nothing, and nothing will irritate an adult more: drives them right up the wall. Mother complains to father that John is sloppy, skipping school, and not home much. Father takes the car away from him and grounds him for three weeks. The kid rebels and thinks his father's a tyrant, the parents start fighting, and everyone's crabbing at sister, who's a model kid being treated like she's not there.

Guilt-ridden

"There'as a lot of blaming, guilt, denial, and defensiveness, with the parents asking where they went wrong. You've never seen people so guilt-ridden." In a parallel parents' group during the eight weeks, they are told the problem has nothing to do with what they did.

In phase two, the youth can still control when, where, and how much of the drug he will use. "Phases one and two are predependent stages, and if we are ever going to do crisis prevention, it has to be here, where their direction can be altered."

Phase three is a graduation into harmful dependency. He no longer associates with non users, getting high is now his first priority, and he needs more and more to feel good. He can no longer move to the normal range of emotion without either using the drug, or getting treatment.

In four years of using this evaluation, 21% of adolescents have moved to this stage, Mr Griffin said. They are sent to a secondary treatment centre for a two-week evaluation in a treatment setting.

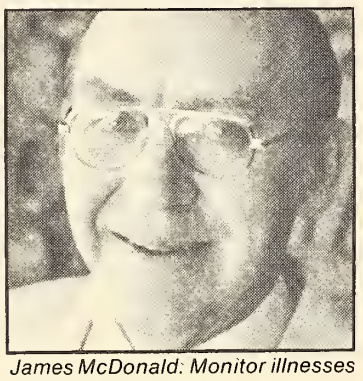
They have not yet had a youth in the fourth, or chronic phase. "There is no more high. He uses the drug just to get to the normal range of emotions every day. He keeps trying to get back that wonderful euphoria, but he will never get it again. He is just trying to survive, to get by with as little pain as possible."

Certified illnesses alcoholism clue

ACAPULCO — One of the best ways to detect alcoholics in industry is to monitor the types of illnesses certified by physicians as requiring a leave of absence, James McDonald told the Third World Congress of the International Commission for the Prevention of Alcoholism and Drug Dependency here.

Among such disorders, he said, were stomach disorders, anemia, liver ailments, epileptic seizures, coronary insufficiency, hypertension, and injuries resulting from fights or accidents. An unusual amount of foot or dental surgery, he added, may indicate heroin abuse, since morphine is commonly prescribed after these procedures.

He is with the Cadillac Division of the General Motors Corporation and deals with employee substance abuse.



James McDonald: Monitor illnesses to spot drug abuse.

The Journal

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Projections

The following selected evaluations of audio-visual materials have been made by the Audio Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six point scale. For further information, contact Jenny Cafiso, coordinator of the group, at (416) 595-6150.

Reading, Writing and Reefers

Number: 342.
Subject Heading: Drug use: etiology and epidemiology (origins and patterns of use); drugs and youth; attitudes and values.
Details: 52 minutes, 16mm, color.
Synopsis: Edwin Newman narrates this documentary about cannabis use among young people in Florida. Mr Newman interviews former or current cannabis users. Most of those interviewed smoke a great deal and often skip school, or tune out if they are there. Since there is a great deal of advertising for cannabis and related paraphernalia in specialized magazines, many feel that it cannot be harmful. However, many changes are taking place: in five years, selective cultivation has increased the potency of THC by 10%; also, further research has shown some harmful effects of cannabis, eg increased heart rate, high levels of tar, tolerance to and long term accumulation of THC in the body. New information concerning cannabis is not reaching young people and more effort must be done to make them aware of these new facts.
General Evaluation: Very good (4.9). Contemporary, with a clear, informative message, this film was rated a good teaching aid that could help in decision-making concerning drug abuse. Public broadcast was recommended.
Recommended Use: This film is likely to benefit audiences of 12 years of age and older.

She Has A Choice

Number: 360.
Subject Heading: Alcohol and the family; alcohol and alcoholism (overview); women and alcohol; attitudes and values.
Details: 17 minutes, 16mm, color.
Synopsis: In this documentary narrated by Carol Mills, the problem of women and alcohol is explored. Some of the commonly held notions about women and alcoholism are challenged by a group of former alcoholic women. Women are often misdiagnosed and treated for emotional problems rather than for alcoholism. It is stressed that alcoholism is a disease and should be treated as such. Women and their families are urged not to cover up the problem. Positive confrontation and intervention are needed.
General Evaluation: Good (4.0). Too much emphasis was placed on the concept of alcoholism as a disease. Blackouts are not as severe a symptom of alcoholism as stated in the film. However, the documentary was judged to be informative, of an appropriate length, and perhaps helpful in attitude change.
Recommended Use: Likely to benefit adult audiences, women, families of alcoholics, and physicians.

It All Adds Up

Number: 356.
Subject Heading: Alcohol and alcoholism.
Details: 11 minutes, ¾" U-Matic video cassette, color.
Synopsis: This videotape explores the problem of alcohol consumption. Comparing countries, the narrators discuss the growth of alcohol use, and the different forms of legislation that have been introduced to regulate it. An increase in alcohol consumption is usually accompanied by increased alcohol related problems: health damage, decreased work performance, and disruption of family life. In Ontario, the significant increase in alcohol use since World War II is the product of various factors: increased availability of alcohol, liberalization of liquor laws, relative decrease in the price of alcohol, as well as the promotion techniques used by the alcohol industry. Some of the possible solutions to the problem are explored. The conclusion is reached that an integrated approach is needed which will combine preventive education with alcohol control policies.
General Evaluation: Very good (5.0). This well produced, contemporary, and informative videotape was considered to be a good teaching aid. General broadcast was recommended.
Recommended Use: The tape is likely to benefit audiences 12 years of age and older. It was recommended particularly for alcohol users, health professionals, teachers, policymakers, and community action groups.

An Easy Pill To Swallow

Number: 349.
Subject Heading: Drug use: etiology and epidemiology; pharmacology.
Details: 28 minutes, 16mm, color.
Synopsis: Pills, including tranquillizers, are widely used. Many of those who are prescribed tranquillizers are women who go to their doctors with unspecified symptoms and are given tranquillizers to reassure them. Unfortunately, many of these women become addicted to these drugs and can become cross-addicted to alcohol, while the problems that led them to take the pills remain. Several women tell how they became addicted and discuss the problems they experienced when trying to stop their use of pills. Dr Ed Sellers of the Addiction Research Foundation of Ontario briefly discusses the current research being conducted on tranquillizers.
General Evaluation: Good (4.5). This contemporary, informative film was rated a good teaching aid and likely to help in decision-making about drug use.

DEPARTMENT

New Books by RON HALL

The Social Control of Drug Use

. . . by the Royal Commission into the Non Medical Use of Drugs, South Australia

The Royal Commission into the Non Medical Use of Drugs has been appointed by the Government of South Australia to inquire into the non medical use of narcotic, analgesic, sedative, and psychotropic drugs or substances of dependence not including nicotine or alcohol. The purpose of this document is to set out tentative views on a number of matters concerned with the social control of drug use, all of which are raised by the Commission's terms of reference. The first part of this discussion paper attempts to reveal some of the more important misunderstandings, and at the same time to provide information on the rates of use of various drugs and on the nature of addiction or dependence. The second part explains the various official controls that are already available in South Australia for regulating the presence or use of drugs. The next part describes the present treatment facilities for drug-dependent people in South Australia. The last part deals with certain specific policy questions.

(GPO, Box 221, Adelaide 5001, South Australia. 1978. 131p.)

A Multicultural View Of Drug Abuse

. . . edited by David E. Smith, Steven M. Anderson, Millicent Buxton, Nancy Gottlieb, William Harvey, and Tommy Chung

The proceedings of the 1977 National Drug Abuse Conference, held in San Francisco, are presented in this volume. Only 70 of the 280 papers submitted are included. The book begins with drug abuse policy regulatory and law enforcement issues, then deals with drug and typology issues focusing on diverse scientific and cross-cultural issues revolving around specific drugs including opiates and non narcotic drugs. In the next section, issues in the controversial areas of combined alcohol and drug abuse treatment are presented. Other sections are devoted to prevention and training issues, treatment and evaluation, vocational rehabilitation and industrial issues, and age, sexual, and multi-cultural issues.

(Schenkman Publishing Company, Inc, 3 Mt Auburn Place, Cambridge, Massachusetts, 02138. 1978. 643p.)

Quasar: Quantitiative Structure Activity Relationships of Analgesics, Narcotic Antagonists, and Hallucinogens

. . . edited by Gene Barnett, Milan Trsic, and Robert E. Willette

As No 22 in NIDA's Research Monograph Series, this volume contains the proceedings of a technical review meeting held by NIDA in April, 1978. The sections are defined according to primary quantitative method used as follows: (I) Pharmaco-chemical methods; (II) Hansch Analysis and Other Empirical Methods; (III) Molecular Mechanics; (IV) Spectroscopic Methods. It has been recognized the use of such techniques as quantum mechanics, molecular spectroscopy, tissue and receptor binding studies, chemical modification of molecular structures, and correlation analysis can be of significant aid in understanding the basic mechanisms of drug action at the molecular level. Much of the work reported has been a product of NIDA's support of research using those approaches on drugs of major concern and interest.

(National Institute on Drug Abuse, 5600 Fishers Lane, Rockville, Maryland, 20857. 1978. 497p.)

Just So It's Healthy

. . . by Lucy Barry Robe

This book is concerned with translating scientific data on the fetal alcohol syndrome and genetic drug damage into everyday language. Specific drugs are named and the genetic damage associated with each is presented. The first part of the book is devoted to drinking during pregnancy, the effects of heavy drinking on babies, moderate or social drinking during pregnancy, and binge drinking during pregnancy. The second part deals with over-the-counter drugs, prescription drugs, and mood-changing drugs.

(CompCare Publications, 2415 Annapolis Lane, Suite 140, Minneapolis, Mn, 55441. 1977. 104p. $2.75.)

Other Books

Addiction Research And Treatment: Converging Trends — Gottheil, Edward L. (Jt ed) et al. Pergamon, New York, 1979. Proceedings of the First Annual Coatesville-Jefferson Conference on Addiction. Selected papers with references from the presentation of the Substance Abuse Treatment Unit from Coatesville Veterans Administration Hospital and the Jefferson Medical College, Philadelphia, Pa, in October, 1977. Treatment as a resource for meaningful research. Translating research into clinical practice. 146p.

Reefer Madness: The History Of Marijuana In America — Sloman, Larry. Bobbs-Merrill, Indianapolis, 1979. A popular social history by a magazine writer for Rolling Stone. Index. 404p.

7th International Conference On Alcohol, Drugs And Traffic Safety, Proceedings — Johnston, Ian R. (ed). Australian Government Publishing Service, Canberra, 1979. Conference held Melbourne 23-28, Jan. 1977. Epidemiological studies and reviews: pharmacological and behavioral studies and reviews: measuring the presence of alcohol: evaluating countermeasure strategies: legislation, enforcement and deterrence, education and information. IX, Reference. 712p.

Statistics For The Social Sciences 2nd Edition — Hays, W. L. Holt, Rinehart and Winston, New York, 1973, Index. 954p. $23.60.

Highlights From Drug Use Among American High School Students 1975-1977 — Johnston, L. D., Bachman, J. G., and O'Malley, P. M. National Institute on Drug Abuse, Rockville, 1978. Prevalence, recent trends, attitudes and beliefs. 43p. $1.90.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell Street, Toronto, Ontario, Canada, M5S 2S1.

Canada

Canadian Addictions Foundation Meeting — Addictions: What Is Treatment — Aug 11-14, 1980, Montreal, Quebec. Information: Vern Lang, CAF, Suite 1100, 251 Laurier Ave W, Ottawa, Ontario, K1P 5J6.

United States

Employee Assistant Programs: Development and Implementation — Dec 5, 12, Amityville, New York. Information: H. Daniel Carpenter, National Association on Drug Abuse Problems Inc, 355 Lexington Ave, New York, NY, 10017.

4th Southeastern Conference on Alcohol and Drug Abuse — Dec 5-9, Atlanta, Georgia. Information: Dr C. Hunter Jr, Medical Director, Addictive Disease Unit, Peachford Hospital, 2151 Peachford Rd, Atlanta, GA, 30338.

Chemical Abuse and Mental Illness: Bridging The Gap — Dec 6-7, Leamington, Hotel, Minneapolis, Minnesota. Information: Diane Campbell, Dept of Conferences, 315 Pillsbury Drive SE, University of Minnesota, Minneapolis, MN, 55455.

Training Institute on Addictions — Dec 9-14, Miami Beach, Florida. Information: Training Institute on Addictions, c/o Dan Barmettler, Institute for Integral Development, PO Box 2172, Colorado Springs, Colorado.

Alcoholism — The Search for the Sources — Jan 23-25, 1980, Greenville, North Carolina. Information: Center for Alcohol Studies, University of North Carolina — Chapel Hill, 335 Medical School Building, 207H, Chapel Hill, NC, 27514.

Poisoning: A Symposium — Feb 11-15, 1980, Denver, Colorado. Information: Director of Professional Education, Rocky Mountan Poison Center, West Eighth and Cherokee, Denver, CO, 80204.

Psychiatry and Alcoholism — March 10-12, 1980, Topeka, Kansas. Information: June Housholder, The Menninger Foundation, Box 829, Topeka, KA, 66604.

National Council on Alcoholism Annual Meeting — May 2-7, 1980, Olympic Hotel, Seattle, Washington. Information: National Council on Alcoholism, 733-3rd Avenue, New York, NY, 10017.

NADC-'80 (Joint conference of the NDC, NDAC, And ADPA — September 1980, Washington, DC.

Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) Annual Meeting — Oct 1980, Washington, DC. Information: ALMACA, 1800 N Kent Street, Suite 907, Arlington, Virginia, 22209.

New Frontiers in Addictive Behaviors: A Conference Cruise to Alaska — June 14-21, 1980. Information: Merry Bush, Kawaguchi Travel Service, Alaska Cruise Program Committee, 711 Dexter Horton Building, Seattle, Washington, 98104.

Abroad

1st Pan-Pacific Conference on Alcoholism and Drug Dependence — Feb 26 - March 7, 1980, Canberra, Australia. Information: Pierre Stolz, AFADD, PO Box 477, Canberra City, ACTG 2601, Australia.

National and Regional Workshop on Drug Abuse — March 10-15, 1980, New Delhi, India. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

26th International Institute on the Prevention and Treatment of Alcoholism — June 9-14, 1980, Cardiff, Wales. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

26th International Institute on the Prevention and Treatment of Drug Dependence — June 15-20, 1980, Cardiff, Wales. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

8th International Conference on Alcohol, Drugs and Traffic Safety — June 23-25, 1980, Umea, Sweden. Information: T80, The Secretariat, PO Box 5071, S-10242, Stockholm, Sweden.

5th World Conference on Therapeutic Communities — Aug 31 - Sept 5, 1980, Noorwijker Hout, Netherlands. Information: Robert Chenevert, Zieken 107, The Hague, Netherlands.

Night Driving Conditions — Nov 20-22, 1980, Paris, France. Information: La Prevention Routiere Internationale, Linas, F-91310 Paris, Montlhery, France.

33rd International Congress on Alcohol and Drug Dependence — 1981, San Jose, Costa Rica. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1970-79

Decade in retrospect —groundwork for the 80s

Betty Lou Lee reports

CANADIANS ENTERED 1970 being asked to take their concerns, opinions, and information about drug abuse and misuse to the Royal Commission on the Non-Medical Use of Drugs: the LeDain Commission.

They're entering 1980 being asked to tell the government their feelings about the decriminalization of marijuana. The prospect of any change in the law is at least a year away.

In the interim 10 years, much of the general attitude to illicit drug use turned from blazing hot to 70s cool. From, "My God, Johnny's smoking dope!" to, "So the kid smokes grass? What's the harm in it, as long as he doesn't get caught?" Or even more commonly, "So the kid gets smashed on booze on the weekends. We did the same when we were that age."

LeDain

Cannabis has been the most publicized and debated illicit drug of the 70s.

The LeDain Commission wrote a whole report on it in 1972, a year before its final report which covered all substance abuse. The majority recommended removal of penalties for simple possession and use, with one commissioner calling for legalization, and one arguing for retention of fines, although reduced ones, for possession.

The commission was generally considered to be "soft" and "permissive" about pot, but it did express concern about the lack of scientific data on the effects of chronic use, and about use of the drug by adolescents.

Since that time, the legislative situation can best be summed up by a headline in **The Journal** late in 1973: Cannabis legislation delayed yet again.

Decriminalization

The three major political parties said last year they supported removal of criminal penalties for possession. But present Health and Welfare Minister David Crombie has said he doesn't want to decriminalize it completely. Federal Justice Minister Jacques Flynn has promised provincial attorneys-general that laws about possession won't be changed until a decision is made about how dangerous the drug is.

The latest government move is a 20-page "discussion paper" on cannabis laws. Mr Crombie hopes it "will be a vehicle to open the door to invite groups from across Canada to write in their opinion on marijuana." The paper outlines recent research, present laws, and possible options to them. He doesn't expect Parliamentary debate for a year.

On the research front, it's been a decade of intense study of the effects of chronic cannabis use, fired by a mass infusion of government funds in the early 70s, and by approval of government-grown crops with a standard THC (tetrahydrocannabinol) content for research in both the United States and Canada. Techniques to measure THC in the blood also allowed more relevant comparisons of animal research and human situations.

That research has pointed to a number of possible targets for damage: lungs, brain, gonads, and the immune system. Primate studies strongly indicate interference with normal reproduction, although no gross fetal abnormalities in

humans have been attributed directly to cannabis use.

Concern has also mounted about the effects of cannabis of the counry's already horrendous rate of highway slaughter.

Ontario has undertaken the first Canadian study of its kind to see how drugs other than alcohol are contributing to that carnage.

Analysis won't be complete until early in 1980, but preliminary results show almost 70% of people who died on Ontario highways in 12 months had consumed alcohol or other drugs before their deaths. Thirteen per cent had one or more drugs than alcohol, usually marijuana, cocaine, LSD, or analgesics. Sixteen per cent had alcohol and at least one other drug, and 39% had only alcohol.

While pot use showed a steady growth pattern in the 1970s, with the age of users spreading both down to pre-adolescents and up to people in their 30s, other drugs fluctuated wildly on the hit parade.

Disco drug

Cocaine emerged as the "disco drug," the choice of the so-called "smart set." Its glitter has become a bit tarnished in Dade County, Florida, centre of the North American distribution market. One killing a week in the Miami area is being attributed to the warring market factions, and gangland-style machine gun slayings are being likened to those in Chicago during Prohibition.

The death toll among cocaine users is now estimated at at least two a week in the US, and perforated nasal septums are being reported increasingly on both sides of the border. In the same way the wheezing bronchitic has become symbolic of the heavy cigarette smoker, the whistling breather whose nose can't be surgically repaired may become the hallmark of the cocaine sniffer who overdid it.

Dr Oriana Kalant of the Addiction Research Foundation, an expert on cocaine, links its rise and fall this century to the rise and fall of amphetamines. Her studies indicate there is no difference in the pharmacological effects of the two.

Coke use fell off in the 1930s, when amphetamines first became available. Benzedrine inhalers for stuffy noses were popular in prisons then, she says, because the drug could be drained out into a cup of coffee.

Angel Dust

Illicit amphetamine use was sharply curtailed in 1972 when Canadian doctors were allowed to prescribe it only for narcolepsy and hyperactivity, and tighter controls were imposed on licit manufacturers. Most of the street supply now comes from illicit labs.

Dr Kalant attributes the "fabulous" prices that users pay for cocaine to snob appeal. And she notes some dealers are cashing in on its similarity to speed by combining amphetamines with procaine, a local anesthetic used by dentists. It gives the same numbing sensation in the nose when sniffed, and dealers are able to pass off the mixture as the much higher-priced coke.

PCP (phencyclidine) or Angel Dust, seemed to hit its peak in Ontario about the mid-70s, but it is still very much around.

And LSD has made a comeback, both in Canada and the US.

Daniel Addario, special agent in charge of the northern California office of the US Federal Drug Enforcement Administration, says seizures of acid have increased 1,500% in two years. By October this year, agents had seized 750,000 doses worth $2.25 million in northern California alone, compared to 51,000 doses in the whole state in 1977.

He said illicit manufacturers arrested in the early 1970s are now out of jail and seem to be back in business.

As the LSD ghost materialized again, so did its high priest. Timothy Leary was busted once more last summer in Los Angeles, although police didn't specify what "dangerous drug" he had in his possession.

Alcohol

Youths who did other drugs in the 1960s turned up their noses at the alcohol their parents used for chemical comfort. But in the 70s they've been bending their elbows at a rate that's become a popular theme for "viewing with alarm." And they've been getting acquainted with alcohol at an ever-younger age.

Every province and territory in Canada lowered its drinking age to 18 or 19 in the early 70s. Ontario did both — lowered it to 18, then raised it by one year in the hope of removing legal drinking from the high school setting.

The biggest impact of the change was to lower the age of users: children in their mid-teens could pass as 18-year-olds, or at least were in the same social milieu as those who could get their alcohol legally.

Motivations attributed to the age lowering were often cynical: it was a bid to tap the younger voting market. Or, it was attempts by governments to switch kids from other drugs to one their parents understood and of which they at least tacitly approved.

Limited surveys and studies indicated an increase in drink-related traffic accidents and violations among the young, and alcoholism treatment centres reported an increase in their caseloads of under-20s having serious problems with drink. There were also indications that many didn't just switch to alcohol from other drugs, but added booze to their roster of both street and prescription drugs.

In treatment, one big move of the 70s was to provide detoxification centres and half-way houses rather than jail cells and drunk tanks for public drunks.

Another was the growth of Employee Assistance Programs, where the clout of possible job loss is used to coerce a worker to get treatment. On paper, many of the programs cover any type of abuse problem; in practice, they deal almost exclusively with alcohol.

The Addiction Research Foundation has set up a centre in Toronto to promote them among more Ontario companies. Only 8% of Ontario employees are now covered by EAPs.

One big advance in alcohol research in the 70s was the description of "fetal alcohol syndrome" in 1973 by a University of Washington team in Seattle.

At first detected among babies of women with obvious alcoholism, it has since been seen in less severe form among babies of "social drinkers," and researchers in that field are now loathe to say there is any "safe level" of alcohol consumption during pregnancy.

Tobacco was the one big exception to 1970s trend: it was the only widely-used and socially-sanctioned drug to come under widespread attack and to become less acceptable.

Clean air bills, anti-smoking bylaws, and segregated smoking sections in restaurants and airplanes flourished. Anti-smokers became organized, aggressive, and, at times, militant.

That, and the mounting pile of evidence of the harmful physical effects of smoking, struck home with at least half the population — the male half. Adult men kicked the habit in increasing numbers, and fewer teenaged boys started. But women continued to puff away, even in the face of evidence of tobacco's effect on the fetus, and the percentage of high school girls who smoke now exceeds that of boys.

Early in the 70s, the LeDain Commission had expresed concern about the mounting use and abuse of prescription and over-the-counter drugs. That concern became much more widespread as the decade drew to a close.

Medical and consumer groups grew increasingly critical of the "pill for every ill" attitude. "Men get drunk, women get tranquillized," became a critical slogan aimed at doctors as Valium became the most prescribed drug in North America.

Canadians' consumption of narcotics rose 25% between 1971 and 1979, and they now lead the world in use of codeine and hydrocodone. The Canadian Medical Association has urged doctors to give more thought to prescribing narcotics, including such products as cough preparations that contain them.

And the fight to plug all the holes in the anti-drug dike continued to shift.

When controls on amphetamines were tightened, there was an increase in the diversion of diethylpropion, a "diet drug" with similar effects, from the licit to illicit markets. Then it was moved from Schedule F to G of the Food and Drugs Act, to give greater control of it at both the manufacturing and prescribing level.

All part of the war that nobody won and nobody lost — in the 70s.

Ms Lee, a regular contributor to *The Journal*, is medical reporter at The Spectator, Hamilton, Ont. She recently completed, with the assistance of five other reporters, a 13-day series entitled *Drugs Now* for that newspaper. The series, which included nearly 60 articles and covered more than 16 full newspaper pages, traced developments in the drug field over the past decade. In conjunction with the series, a 33-page teachers' guide was prepared by the educational coordinator of the newspaper's community services department.

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